Approved: 4/1/09
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:30 p.m. on March 2, 2009, in Room 136-N of the Capitol.

All members were present.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Kelly Navinsky-Wenzl, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Jan Lunn, Committee Assistant

Conferees appearing before the committee:
Dr. Marci Nielsen, Executive Director, Kansas Health Policy Authority
Jeff Ellis, Lathrop and Gage
Tom Bell, President, Kansas Hospital Association
Jerry Slaughter, Executive Director, Kansas Medical Society
Jeff Bloemker, Cerner Corporation

Others attending:
See attached list.

Informational Briefing on Health Information Technology (HIT)/Health Information Exchange(HIE)
Senator Barnett opened the informational briefing with comments about the capability to electronically move clinical information among disparate systems while maintaining the integrity of the information being exchanged. The goal is to access and to retrieve clinical data to provide safer, more timely, efficient, effective, equitable, and patient-centered care. This topic is of particular importance with the recent passage of the American Recovery and Reinvestment Act (ARRA).

Dr. Marci Nielsen, Kansas Health Policy Authority, distributed her testimony (Attachment 1) which included a one-page fact sheet, the National Governors' Association detailed version, and a hand-out relative to HIT/HIE plan development for Kansas. Dr. Nielsen provided information regarding available dollars to focus on HIT/HIE through ARRA. She indicated that in the United States, the best health care in the world is offered, but not the best health care system. Our current system lacks recognition of:
a.) the complexity of information technology undertakings;
b.) the need to integrate all aspects of projects;
c.) work and physical environments;
d.) and regulatory/policy requirements while engaging all the parts and participants in harmony.

Dr. Nielsen discussed the definition of a medical home, operationalizing the medical home, improving quality through health information technology, the history of Kansas HIT/HIE initiatives, and concluded with information on aligning the Kansas HITECH (Health Information Technology Economic and Clinical Health Act) plan.

Jeff Ellis, JD, Chair, Health Information Privacy and Security Collaboration (HISPC) and Chair of the Kansas HISPC Legal Work Group, discussed the background of the HISPC project from 2006 to the present time. The project included a steering committee and four work groups: Variations Work Group, Legal Work Group, Solutions Work Group, and the Implementation Work Group. The overall project outcomes were to develop a full understanding of variations in business and privacy/security policies and practices, to design practical solutions and implementation plans for health information systems while preserving privacy/security, and to establish long-lasting collaborative networks for states and communities to support future work. Mr. Ellis' testimony is attached, and therefore becomes part of this permanent record (Attachment 2). Mr. Ellis introduced Helen R. Connors, PhD, RN, FAAN, Chair, Kansas HISPC Steering Committee, and Julie A. Roth, MHSA, JD, and member of the Kansas Legal Work Group. Ms. Roth and the Legal Work Group developed the Comparative Analysis Matrix (CAM) and Assessment Tool which contains over 150 areas of subject matter addressed in state law that involves or impacts health information disclosure. It is designed to facilitate comparison and analysis of state laws

by providing the framework for consistent and structured review. Mr. Ellis concluded his testimony by reporting that Kansas' HISPC accomplishments provide a mechanism to analyze state law and regulations through the CAM and Assessment Tool, as well as a blueprint for educating Kansas consumers and providers regarding the value of health information exchange and implementation methods.

Tom Bell, president, Kansas Hospital Association, testified (Attachment 3) the vision created through the American Recovery and Reinvestment Act is to include enhanced efficiencies through reduced paperwork, to eliminate duplicative or unnecessary testing, and to provide better decision support at the point of care. He included a summary of frequently asked questions, and a summary of the impact to Kansas of the American Recovery and Reinvestment Act. Mr. Bell shared that opportunities exist to capture federal dollars with the implementation and use of electronic information or an electronic health record (EHR). Mr. Bell discussed what the State has done to prepare for health information technology implementation, and he recommended that communication with the federal Secretary of Health and Human Resources occur as soon as possible encouraging rules and regulations development for provisions contained in the ARRA.

Jerry Slaughter, Kansas Medical Society, speaking from physicians' perspectives (Attachment 4), reminded committee members that while federal dollars could be forthcoming for implementation and expansion of HIT/HIE, there are still many unanswered questions. The recent passage of ARRA provides immense authority to the federal Secretary of Health and Human Services, and it could be several years before the impact of the legislation is realized. While the state of Kansas is well positioned and proactive, the Kansas Medical Society and its physician membership will continue to watch carefully the rules and regulations that are promulgated with the passage of this legislation as well as potential impact to all physicians' practices.

Jeff Bloemker, Cerner Corporation, provided a history of the Cerner Corporation. He indicated that Kansas is on the forefront of health care reform with the implementation of regional health information organizations (RIOS) through Cerner software (Attachment 5). He spoke about a community health record (CHR), the adoption of a Care and Trust Program for health information data, coordination of care for Medicare patients, understanding of information as critical for chronic disease management, and the importance of developing partnerships to create a tipping point to eliminate waste, fraud, abuse, and duplicative testing. He supported piloting the virtual medical home concept.

Senator Schmidt moved to approve the minutes of the February 2, 3, and 4, 2009, meetings as submitted; Senator Brungardt seconded the motion. The motion passed.

The next meeting is scheduled for March 3, 2009.

The meeting was adjourned at 2:30pm

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: March 2, 2009

NAME	REPRESENTING
Sue Ewest	KAHSA.
Chad Austin	KHA
Jeff Bloemker	Cerner
Cynthia Smith	SCL Health System
Barb Sanger	KHPA
Erik Nyberg	ACMHCKA
Celia Thornsett	ACMHCK
Keith Rickard	ACMHCK
Christine Steph	KHI
Julie Roth	HISPC
Jeff Ellis	HISPC
Helen Connors	HISPC
Larry Pitman	KFMC
Todd Fleischer	Ks. optometric Association
GARY CARUTHERS	KMS
Susan Zalenski	g+g
Doris Hein	Hein Law Firm
Tracy Russell	Ks. Health Consumer Coalition
CRAIG DIESO	CERNER
Melissa Hungerford	Ks Hosp Assn

Connie Hubbard	KAMC
Marty Kennedy	KDOA
Christina Morris	KBOP
CHAD Austin	KHA
FRED LUCKY	KHA
~~Mike Reecht~~	~~Jacobs Braden~~
Nancy Zogleman	Polsinelli
Frank Whitelaw	KBOP
Anne Geiss	American Cancer Society
Dan Morin	KS Medical Society
Pat Vogelberg	Kearney

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KANSAS HEALTH POLICY AUTHORITY

American Recovery and Reinvestment Act (ARRA)
Health-Related Provisions Fact Sheet
02-23-2009

Medicaid: $440 Million over 9 quarters 10/1/2008 - 12/31/2010

- Increase Federal Medical Assistance Percentage (FMAP) from 60.08% to 66.28%
- Provides additional 11.5, 8.5 and 5.5 percent increase based on change in unemployment rate
- Maintenance of Effort (MOE) requirement to neither decrease NOR increase eligibility to receive FMAP increase
- Extends moratorium for TCM, provider taxes, school based administration and transportation services through 6/30/09
- Adds moratorium on hospital outpatient services regulation through 6/30/09
- Transitional Medical Assistance (TMA) through 12/31/2010

ARRA FMAP Projections By Fiscal Year				
	SFY 2009	SFY 2010	SFY 2011	Total
KHPA	56,030,789	109,652,302	64,710,265	230,393,356
Aging	21,028,902	37,860,903	22,185,177	81,074,982
SRS	33,957,299	59,566,100	34,918,598	128,443,997
TOTAL	111,016,991	207,081,304	121,814,041	439,912,336

- Exact amounts may vary, depending on Kansas unemployment rate
- Distribution of funds among agencies depends on caseload requirements
- Temporary increase in Medicaid DSH funding: ARRA increases state spending limits for disproportionate share hospital (DSH) payments by 2.5% in federal fiscal year 2009 and another 2.5% in FFY 2010, resulting in an additional $750,000 in federal matching payments in FFY 2009 and an additional $2.1 million in FFY 2010. Additional state matching funds of about $340,000 in FY 2009 and $710,000 in FY 2010 will be required to draw down these funds.

Health Information Technology (HIT): $19 Billion (Total)

- $2 billion in competitive grants for funding for HIT Infrastructure
- Medicare and Medicaid incentives for providers to use HIT electronic health records ($17 billion)
- Requires federal government to take a leadership role to develop interoperability standards by 2010 to allow for HIE
- Strengthens federal privacy and security law to protect from health information misuse
- State of Kansas well positioned for federal funding given work of the Governor's Cost Containment Commission, the Kansas HIE Commission, the Health Information Security and Privacy Collaboration, and the E-health Advisory Council -- Kansas "Roadmap" recommendations:
  - Create public-private coordinating entity: *E-health Advisory Council*
  - Provide stakeholder education: *Kansas Health Online*
  - Leverage existing resources: *KHPA has two ongoing Health Information Exchange (HIE) pilots: Sedgwick County (Medicaid managed care); KC Metro Area (state employees)*
  - Demonstrate impact of HIE and foster incremental change: *HIE pilots; challenges re: interoperability, sustainable funding, ROI*
  - Address privacy and security barriers: *Kansas HISPC initiative*
  - Seek funding from multiple sources: *Looking for foundation support for HIT/HIE and medical home model of health care delivery*
- E-health Advisory Council, agencies, stakeholders to develop plan for obtaining federal stimulus dollars

Other ARRA HEALTH-RELATED Provisions

COBRA Health Care for Unemployed: $24.7 Billion (Total, estimate)

- Consolidated Omnibus Budget Reconciliation Act, 1986
- Provides opportunity for workers to keep employer-based health benefits after leaving a job
- Employee typically pays 102% of premiums
- No direct state involvement
- ARRA provides a 65% subsidy for those who purchase COBRA coverage
- Possible involvement of Kansas Insurance Dept. and Department of Labor

Health Resources and Services Administration: $2.5 Billion (Total)

- $1.5 billion for Community Health Centers (CHCs) to construction, renovation and equipment for the acquisition of health information technology systems
- $500 Million for services provided at community health centers
- $500 Million for health professions training programs: includes $300 million for National Health Service Corps recruitment and field activities; $200 million for disciplines trained under provisions of Public Health Service Act
- Fosters cross-state licensing agreements for health professionals

Other Agency Health/Health Care Related Initiatives

- **Kansas Department of Health and Environment (KDHE):** Pandemic Flu Preparedness; Prevention and Wellness funds; Women, Infant and Children (WIC) – other environmental initiatives
- **Social and Rehabilitation Services (SRS):** Transitional Medicaid Assistance; Food Assistance – other assistance initiatives
- **Kansas Department of Aging (KDOA):** Nutrition Services; Medicaid related provisions; Prevention and Wellness Fund – other assistance initiatives

Public Health and Welfare
Date: 03/02/09
Attachment: 1

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KANSAS HEALTH POLICY AUTHORITY

American Recovery and Reinvestment Act (ARRA):
Health Information Technology/Exchange (HIT/E)

Kansas HITECH Plan

Background: As many of you are aware, the American Recovery and Reinvestment Act (ARRA) or "federal stimulus package" was recently signed into law by President Obama. Included in ARRA are several health related provisions that will have an impact on patients, providers, and purchasers in Kansas. Although a significant amount of the funding flows directly into specific Kansas programs (such as Medicaid – with an increased amount of federal matching funds), there are also some competitive funding opportunities, particularly for Health Information Technology (HIT) and Exchange (HIE). The provision of the stimulus bill that includes about $19 billion to fund HIT and HIE projects is Health Information Technology for Economic and Clinical Health, or **HITECH**. As shared with stakeholders' groups, specifically the E-health Advisory Committee and the Medical Home Working Group, these new resources provide Kansas with a tremendous opportunity to build on past efforts related to the health information technology/exchange initiative. Lieutenant Governor Mark Parkinson has assembled a group of state leaders to prepare for implementation of the stimulus package in Kansas, of which KHPA Executive Director is a member. He has asked members of the Cabinet and other state leaders to strategize about how Kansas can compete for these federal funds. HIT and HIE have been a consistent focus of the Kansas Health Policy Authority's long-term strategy for health reform in Kansas. There will be an even greater focus as the agency begins to collaborate with Cabinet Secretaries and stakeholders on ways to utilize these additional funds.

Partnerships: The KHPA through the E-health Advisory Council (with membership appointed by the Governor and KHPA) and under the direction of the Lieutenant Governor and Governor will be leading the initiative to obtain federal funding for the Kansas HITECH Plan. The goal is to use the HITECH dollars to advance health care coordination in the state and to improve health outcomes. Cabinet Secretaries in the Kansas Department of Health and Environment (KDHE), Social and Rehabilitation Services (SRS) and the Kansas Department of Aging (KDOA) have been asked to provide KHPA with their list of HIT/HIE projects that may qualify for HITECH funding consistent with overall goals. The Health Information Security and Privacy Collaborative (HISPC) and other stakeholders also have plans and projects consistent with federal stimulus funds. This information will be used in the development of the Kansas HITECH Plan; the engagement process for the development of this Plan is described below.

Plan for Engagement: KHPA is working with HISPC, the E-Health Advisory Council, the Medical Home Working Group, the Telemedicine/Telehealth Working Group and other interested parties to convene an all-stakeholders meeting to discuss potential HITECH projects for the state. The first all-stakeholders meeting is expected to be held in March. The goal of the steering committee will be to develop ways to use the HITECH dollars to advance health care coordination in the state and improve health outcomes. An email "list-serve" is being established to keep all interested parties apprised of these efforts. Committee updates and meeting materials will be posted to the KHPA website.

3-2-09

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Medicaid and HealthWave:
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State Employee Health Plan:
Phone: 785-368-6361
Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995

Analysis of American Recovery and Reinvestment Act
Date: February 13, 2009

HEALTH AND HUMAN SERVICES

Enhanced Federal Medical Assistance Percentage (FMAP) (Title V, Sec 5001)
Hold harmless. The state's FMAP for federal FYs 2009, 2010 and the first federal fiscal quarter of 2011 (through December 31, 2010) would be no lower than the state's FMAP for FY 2008.

Across-the-board increase. All states would be eligible for a 6.2 percentage point FMAP increase beginning October 1, 2008 through December 31, 2010, after application of the hold harmless provision.

High unemployment states. States with significant changes in unemployment would be eligible for an additional FMAP increase determined through a formula as described below.

States would be evaluated on a quarterly basis. The reduction in the state share would be based on the state's unemployment rate in the most recent three-month period for which data are available compared to its lowest unemployment rate in any three-month period beginning on or after January 1, 2006. The unemployment adjustment tiers are:

- 5.5%: unemployment increase of at least 1.5 but less than 2.5 percentage points
- 8.5%: unemployment increase of at least 2.5 but less than 3.5 percentage points
- 11.5%: unemployment increase of 3.5 percentage points or more

The state's percentage reduction could increase over time as its unemployment rate increases, but if unemployment decreased, the state share would not decrease until the fourth quarter of federal FY2010, which begins July 1, 2010, unless the state otherwise did not meet certain requirements as described below. The state would receive 60 days notice if its share of Medicaid costs were scheduled to increase after this time.

Calculation: If the state qualifies under one of these unemployment tiers, the state would still receive the 6.2 percentage point increase, however, it is easier to think of this as two separate increases of 3.1 percentage points (see Examples A and B below). There are three basic steps for the calculation of the unemployment adjustment:

- Step 1: An increase of 3.1 ***percentage points (half of 6.2)*** in the state's FMAP
- Step 2: A decrease in the state match by the ***percent*** corresponding to the applicable unemployment adjustment tier
- Step 3: Increase the FMAP by an additional 3.1 ***percentage points (the remaining half of 6.2)***

EXAMPLE A: The state FMAP is 50 percent and there was a change in unemployment rate for the quarter of 1.2 percentage points.

- *Step 1: Increase FMAP by 3.1 percentage points:*

FMAP = 50+3.1= 53.1. State share is now 46.9

- *Step 2: Determine unemployment factor, which because the unemployment rate was below 1.5, is zero.*
- *Step 3: Increase FMAP by an additional 3.1 percentage points: FMAP = 53.1+3.1= 56.2*
- *RESULT: state share is 43.8, federal share is 56.2*

EXAMPLE B: The state FMAP is 50 percent and there was a change in unemployment rate for the quarter of 2.0 percentage points.

- *Step 1: Increase FMAP by 3.1 percentage points: FMAP = 50+3.1=53.1. State share is now 46.9*
- *Step 2: Determine unemployment factor: 2.0 percentage point increase qualifies state for 5.5% reduction. Multiply your state share by this percent: 46.9*.055=2.58. Therefore reduce the state share by 2.58 percentage points: 46.9-2.58= 44.32. Result: state share 44.32, federal share 55.68*
- *Step 3: Increase FMAP by 3.1 percentage points: 55.68+3.1= 58.78*
- *RESULT: state share is 41.22, federal share is 58.78*

Commonwealths and Territories. They may choose the 6.2 percentage point increase plus a 15 percent increase in the capped amount or a 30 percent increase in the capped amount.

Application of FMAP to other programs/services. FMAP increases do not apply to payments for Title IV Parts A (Temporary Assistance for Needy Families, TANF), B (Child and Family Services), and D (Child Support and Establishment of Paternity), the State Children's Health Insurance Program (SCHIP), disproportionate share hospitals (DSH), and other enhanced payments based on FMAP.

Title IV-E: The hold harmless and 6.2 across-the-board percentage point increases in FMAP do apply to Title IV-E payments (Foster Care and Adoption Assistance). However, reductions in the state share due to the unemployment-related increase do not apply.

Requirements and Restrictions. ARRA includes several requirements/ and restrictions and prohibits the HHS Secretary from waiving these. These include:

- States may not have eligibility standards, methodologies, or procedures in place in the Medicaid state plan or a Sec. 1115 waiver program that are more restrictive than those in effect as of July 1, 2008.
  - Any state that implemented more restrictive policies since July 1, 2008, has until July 1, 2009 to restore such policies. The state would then be fully eligible for the enhanced match, retroactive to October 1, 2008.
  - Any state that implements more restrictive policies as of July 1, 2008 and restores such policies after July 1, 2009 will be eligible for the enhanced FMAP beginning with the first calendar quarter that it restored the eligibility policies.

- Certain exceptions apply for delay in approval of a plan or waiver.

- The FMAP increases do not apply to payments for individuals enrolled in Medicaid as a result of an expansion in the state income eligibility policies implemented on or after July 1, 2008. States would still receive their regular FMAP for such individuals.
- The state must report on compliance with provider prompt payment requirements beginning with the date of enactment of the ARRA. Extends prompt pay requirements to nursing facilities and hospitals beginning June 1, 2009. Allows the Secretary to waive this requirement in certain situations.
- The state may not increase the percentage of the non-federal share it requires from local governments, above that in place as of September 30, 2008. This requirement is not applicable for the hold harmless.
- Prohibits states from depositing funding from the increased FMAP rate into any state reserve or rainy day fund. This does not apply to increases due to the hold harmless.
- Increases may not result in the state FMAP being greater than 100 percent.
- State must submit report on its use of the additional federal funds from the enhanced FMAP By September 30, 2011.

Federal Oversight of Medicaid Funds

The Act appropriates an additional $31.25 million for the HHS Office of Inspector General (OIG) for October 1, 2008 through September 30, 2011. These funds are intended to be used to ensure the proper expenditure of federal Medicaid funds. In addition there is $5 million in FY2009 to the Centers for Medicare and Medicaid Services (CMS) for implementation and oversight of the state fiscal relief provisions relating to Medicaid.

Temporary Increase for Disproportionate Share Hospitals Payments (DSH) (Title V, Sec 5002)

Temporary 2.5% increase in the state Medicaid DSH allotment for FYs 2009 and 2010. For FY 2010, the increase is based on the adjusted FY 2009 level.

Medicaid Regulations (Title V, Sec 5003)

Delays or addresses several Medicaid regulations, including:

- Extends the current moratoria (P.L. 110-252), on three Medicaid regulations through June 30, 2009: optional targeted case management services (TCM), school administration and transportation services, and provider taxes.
- Applies a new moratorium through June 30, 2009 to the final regulation regarding Medicaid outpatient hospital facility services (73 Federal Register 66817).
- Includes a "Sense of Congress" that the HHS Secretary should not issue final regulations for pending rules on: cost limits on public providers, graduate medical education (GME) payments and rehabilitative services.

Transitional Medical Assistance Extension and Reporting Requirement (Title V, Sec 5004)

Extends the Medicaid Transitional Medical Assistance (TMA) option for 18 months, through December 31, 2010. It gives states the option to extend the initial period of

eligibility for TMA to 12 rather than the current six months and to waive certain enrollment requirements, beginning July 1, 2009.

Beginning July 1, 2009, states would be required to report monthly enrollment and participation rates for adult and child enrollees and the number of these who become eligible under another Medicaid category or for SCHIP.

Qualifying Individual Program Extension (Title V, Sec 5005)
Extends through December 31, 2010 the Qualifying Individual (QI) program.

- $412.5 million is allocated from January 1, 2010, through September 30, 2010.
- $150 million is allocated from October 1, 2010, through December 31, 2010.

State Option for Family Planning Services. No provision.

Medicaid Provisions Impacting American Indians (Title V, Sec. 5006)
The Act includes provisions impacting health care for American Indians, including:

- Prohibits state Medicaid programs from imposing cost-sharing requirements on Medicaid-eligible American Indians when the beneficiary is receiving services from an Indian health care provider or from a Contract Health Services (CHS) provider.
- Exempts certain tribal, religious, spiritual, or cultural property from being considered an asset of an individual Indian for purposes of determining Medicaid and SCHIP eligibility or estate recovery.
- Requires states consult on an ongoing basis with Indian Health Programs and Urban Indian Organizations.
- Applies Medicaid and SCHIP managed care rules to Indian health care providers.

COBRA Healthcare for the Unemployed (Title III, Sec. 3001)
Under current law, individuals losing employment may be eligible to continue their employer-based health care coverage under a program known as COBRA. This entitles the individual to continued access to the same health plan they were receiving, but the individual is generally responsible for 102% of the total cost of the monthly premium.

COBRA continuation subsidy. The COBRA continuation subsidy is available to individuals involuntary separated from their employer on or after September 1, 2008 and before January 1, 2010. The federal subsidy is 65% of the monthly COBRA premium for the individual – and their spouse and dependents – for a period of nine months. The Act places an income threshold on eligibility for the subsidy of $145,000 for individuals and $290,000 for couples. The subsidy is phased-out for individuals with income between $125,000 and $145,000 and couples with income between $250,000 and $290,000.

The subsidy is payable directly to the health plan or other eligible entity as an offset in payroll taxes. It does not count toward the individual's gross income with respect to taxation or eligibility for other government programs. Individuals are no longer eligible for the subsidy once they are eligible for another group health plan.

Eligible COBRA plans. COBRA continuation coverage is that required to be offered by the employer or under a state program that provides continuation coverage comparable to that the individual received from their former employer ("mini-COBRAs"). It also includes continuation coverage requirements that apply to health plans maintained by the federal government or a state government.

The individual may chose a COBRA continuation plan that is *different* than the one he/she was enrolled in at the time of separation as long as the plan is:

- Approved by the employer;
- Available to active employees of the employer;
- The premium for the different coverage is not higher; and
- The different coverage is not: service specific, for example dental or vision only coverage, a flexible spending arrangement, and on-site medical care coverage only.

State Medicaid option for the unemployed. No provision.

Health Information Technology (HIT) (Title XIII)

In brief, ARRA lays the foundation to adopt national HIT standards, provide incentives for adoption and use of HIT, and addresses privacy and security issues. The proposal includes approximately $2 billion to invest in health information technology infrastructure and $17 billion in incentives for Medicare and Medicaid providers.

Office of the National Coordinator for Health Information Technology (ONC). The ARRA codifies the ONC for Health Information Technology within the Department of Health and Human Services and defines the duties of the National Coordinator, which would include developing standards, coordinating HIT policy across policies and programs within HHS and across other executive branch agencies, and updating specific aspects of the Federal HIT Strategic Plan (developed as of June 3, 2008). The bill requires that this plan address utilization of electronic health records by 2014. It also would create HIT Policy and Standards committees, though state representation is not specifically required.

National standards. By December 30, 2010, it requires the Secretary to adopt an initial set of standards, implementation specifications, and certification criteria. It makes adoption of certain standards and certifications by private entities voluntary.

State grants to promote HIT (Title XIII, Sec. 13301). The proposal would establish a program whereby states or a state-designated entity could receive grants for planning or implementation to assist with and expand adoption of HIT. For grants awarded prior to FY 2011, the Secretary may determine if a state match is appropriate. Beginning in fiscal year 2011, there is a state match requirement that is equal to or greater than a defined percent of the federal contribution for grants awarded in FY 2011 as follows:

- FY 2011, not less than $1 for every $10 of federal grant funding;
- FY 2012, not less than $1 for every $7 of federal grant funding; and
- FY 2013 and thereafter, not less than $1 for each $3 of federal grant funding.

The proposal directs assistance for implementation of health information technology, with the goal that funding could be used for the following

- HIT architecture that will support the nationwide electronic exchange;
- Integration of HIT into training of health professionals and others in the healthcare industry;
- Training on and dissemination of information on best practices to integrate HIT into a provider's delivery of care. Such efforts must be coordinated between HHS and state agencies administering Medicaid and the State Children's Health Insurance Program (SCHIP);
- Regional or sub-national efforts towards health information exchange;
- Infrastructure and tools to promote telemedicine; and
- Promotion of the interoperability of clinical data repositories or registries.

Grants to states to create loan programs. The proposal would create a competitive grant program to allow eligible states or Indian tribes to establish a certified electronic health record (EHR) technology loan fund.

Grants to states/tribes could be awarded no earlier than January 1, 2010. States would be required to match federal contributions of at least $1 for every $5 in federal grant funding. Public funds and private sector contributions are permissible sources for the non-federal match.

The loan fund would allow states/tribes to distribute a loan to a provider or other eligible entity if the provider/entity agrees to certain requirements, for example providers must agree to report on quality measures. Private sector contributions to the loan fund are permissible. Loan funds could only be used for specified EHR-related technology purposes.

Medicaid HIT-related funding (Title IV, Sec. 4201). States may reimburse eligible Medicaid providers for the cost of qualified electronic health record (EHR) purchases, implementation and certain operation costs. The federal financial participation (FFP) rate for such payments is:

- 100 percent for Medicaid providers' purchase of certified EHR, including training and maintenance.
- 90 percent for certain administrative expenses.

The reimbursement payment for non-hospital based Medicaid providers with 30 percent Medicaid caseload is:

- 85 percent of the net allowable costs incurred for the purchase, implementation, and use of certified EHR technology.
- A separate reimbursement is applied for children's and acute care hospitals.
- Other hospitals are to be reimbursed according to the Medicare incentive policy.

The higher FFP is contingent upon states meeting several requirements, including:

- Determine providers are demonstrating "meaningful use" of the EHR technology, as determined by the state and HHS Secretary;
- Reimburse providers directly, without a deduction or rebate; and
- Track the use of EHRs, conduct oversight, encourage adoption of certified EHRs and exchange of health care information.

Limits are placed on provider "incentive" payments – which may be more appropriately characterized as a reimbursement payment, including:

- $25,000: maximum net allowable costs for purchase and initial implementation.
- $10,000: maximum net allowable costs for subsequent year EHR related expenses.
- $63,750: aggregate maximum net allowable costs.
- Reimbursement is limited to five years and cannot be provided after 2021.
- Providers would be responsible for any technology related expense not referenced.

The Act seeks to minimize duplication and harmonize requirements for providers participating in both Medicaid and Medicare.

Privacy provisions (Title XIII, Sec. 13400). The proposal includes provisions to strengthen privacy and security laws impacting identifiable health information. It does not appear to preempt state law. Provisions address breach notifications processes. It does not include a private right of action. It would provide some enforcement authority on behalf of individuals to states' Attorneys General and would establish a method to distribute civil monetary penalty or monetary settlements collected.

Prevention and Wellness Fund

$1 billion is designated for the Department of Health and Human Services to administer a "Prevention and Wellness Fund." HHS must provide Congress with operating plans prior to obligating any monies from the Fund in fiscal years 2009 and 2010. These funds are to be distributed according to the public health priorities of the Secretary of Health and Human Services and the Director of the Centers for Disease Control and Prevention (CDC). Specific funding allocations include:

- $300 million for the CDC 317 immunization program;
- $650 million for evidence-based clinical and community-based prevention and wellness strategies, authorized under the Public Health Services Act and determined by the Secretary, that deliver measurable health outcomes that address chronic disease rates; and
- $50 million to states to implement healthcare-associated infection prevention strategies.

Healthcare Effectiveness Research

$1.1 billion is provided to speed development and dissemination of research assessing the comparative effectiveness of health care treatments and strategies. The bill establishes the Federal Coordinating Council for Comparative Effectiveness Research which is tasked with coordinating comparative effectiveness and related health services research

conducted or supported by federal departments and agencies in order to reduce duplication and leverage resources.

Community Health Centers (CHCs)
$1.5 billion is directed to federally qualify health centers (FQHCs) for construction, modernization, health information technology improvements. An additional $500 million is appropriated for FQHC grant funding for services and operations.

Training Primary Care Providers
The ARRA makes additional investments in health care workforce development programs, including:

- $300 million for the Nation Health Service Corps recruitment and field activities.
- $200 million for primary care medicine, dentistry, public health and preventive medicine program, scholarship and loan repayment programs under PHSA Titles VII and VIII, and cross-state licensing for health specialists.

Aging Services Programs
An additional $100 million is provided for certain "Aging Services Programs" included in the Older Americans Act.

Indian Health Service Facilities
Approximately $727 million is to modernize hospitals and health clinics and make healthcare technology upgrades in underserved rural areas.

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KANSAS HEALTH POLICY AUTHORITY

HIT/HIE & Medical Home Model: Kansas HI TECH Plan

March 2, 2009

Marcia Nielsen, PhD, MPH
Executive Director
Kansas Health Policy Authority

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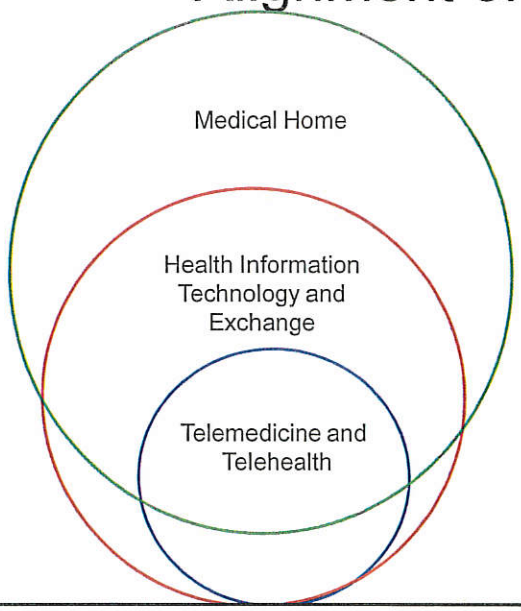
Alignment of Initiatives



Goals:

- **Improve health**
- **Improve coordination of care**
- **Reduce duplication of services**
- **Contain health care costs**
- **Obtain one time federal stimulus dollars for Kansas**

2

Federal Stimulus Package

- **Improving Care Coordination:** Saving the government $10 billion, and generating additional savings throughout the health sector, through improvements in quality of care and care coordination, and reductions in medical errors and duplicative care.
- **Investment in HIT/HIE**: Investing $19 billion in health information technology infrastructure and Medicare and Medicaid incentives to encourage doctors and hospitals to use HIT to electronically exchange patients' health information.
- **Providing funds to States**: Legislation provides funding for health information technology infrastructure, training, dissemination of best practices, telemedicine, inclusion of health information technology in clinical education, and State grants to promote health information technology.

3

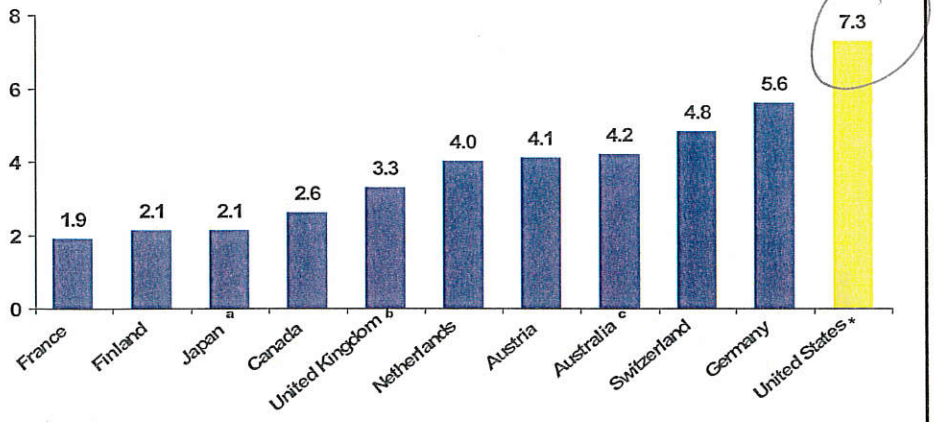
Background: Health Care Challenges

4

EFFICIENCY

Percentage of National Health Expenditures Spent on Health Administration and Insurance, 2003

Net costs of health administration and health insurance as percent of national health expenditures

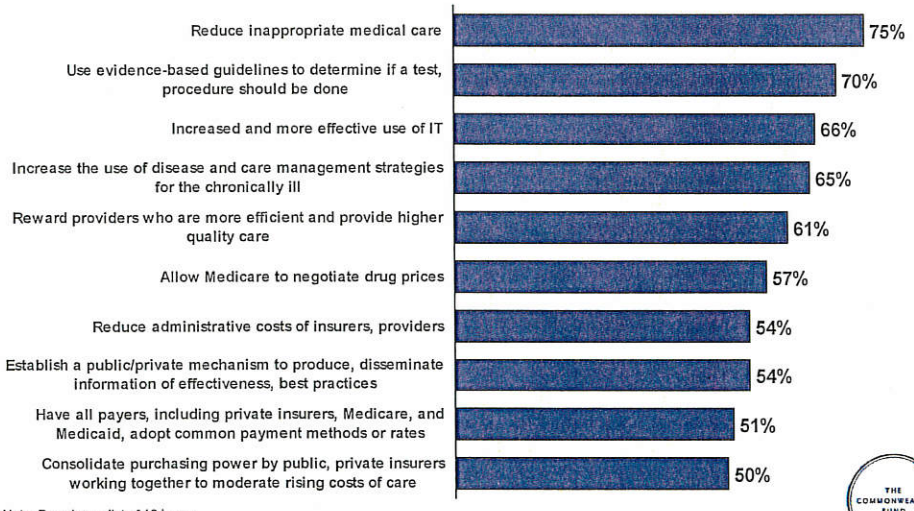


[a] 2002 [b] 1999 [c] 2001
* Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.
Data: OECD Health Data 2005.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

Health Care Opinion Leaders: Views on Controlling Rising Health Care Costs

"How effective do you think each of these approaches would be to control rising costs and improve the quality of care?" Percent saying "extremely/very effective"

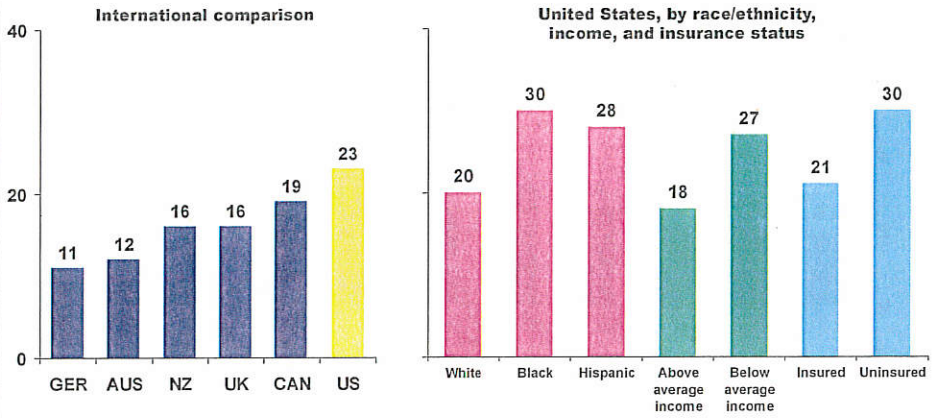


Note: Based on a list of 19 issues.
Source: The Commonwealth Fund Health Care Opinion Leaders Survey, Jan. 2007.

EFFICIENCY

Test Results or Medical Record Not Available at Time of Appointment, Among Sicker Adults, 2005

Percent reporting test results/records not available at time of appointment in past two years



GER=Germany; AUS=Australia; NZ=New Zealand; UK=United Kingdom; CAN=Canada; US=United States.
Data: Analysis of 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults; Schoen et al. 2005a.

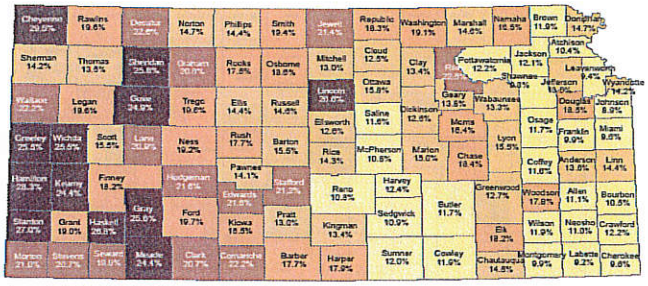
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

Getting Value for Money: Health System Transformation

- Transparency; public information on clinical quality, patient-centered care, and efficiency by provider; insurance premiums, medical outlays, and provider payment rates
- Payment systems that reward quality and efficiency; transition to population and care episode payment system
- Patient-centered medical home; Integrated delivery systems and accountable physician group practices
- Adoption of health information technology; creation of state-based health insurance exchange
- National Institute of Clinical Excellence; invest in comparative cost-effectiveness research; evidence-based decision-making
- Investment in high performance primary care workforce
- Health services research and technical assistance to spread best practices
- Public-private collaboration; national aims; uniform policies; simplification; purchasing power

Where are the uninsured in Kansas?

Percent of People Under 65 without Health Insurance by Kansas County
2005



Source: Institute for Policy & Social Research; data from the U.S. Census Bureau, Small Area Health Insurance Estimates, 2005.

KU INSTITUTE FOR POLICY & SOCIAL RESEARCH
The University of Kansas

Percent Uninsured

Kansas 12.4%

- 8.9 - 12.4
- 12.5 - 15.8
- 15.9 - 19.7
- 19.8 - 22.6
- 22.7 - 29.5

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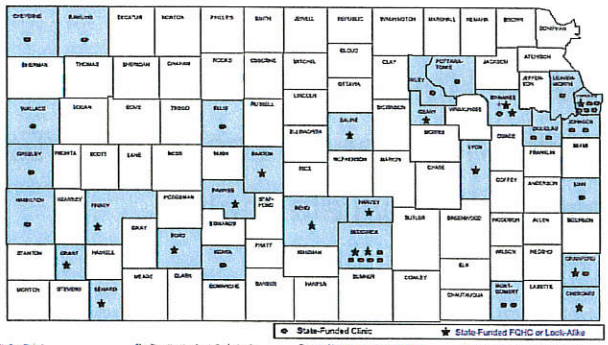
Safety Net Clinic locations in Kansas

2009 State-funded Clinic Sites by County



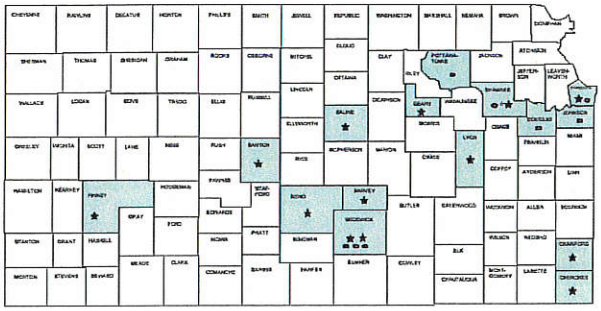
State-Funded Clinic ★ State-Funded FQHC or Look-Alike

Barton: We Care Project
Cherokee: Community Health Center of Southeast Kansas
Cheyenne: Cheyenne County Hospital Clinics
Crawford: Community Health Center of Southeast Kansas
Mercy Health System
Douglas: Health Care Access
Heartland Clinic
Ellis: First Care Clinic
Finney: United Methodist Mexican-American Ministries
Ford: United Methodist Mexican-American Ministries
Geary: Konza Prairie Community Health Center
Grant: United Methodist Mexican-American Ministries
Greeley: Greeley County Family Practice
Hamilton: Hamilton County Family Practice
Harvey: Health Alliance Clinic (Look-Alike)
Johnson: Health Partnership Clinic of Johnson County
Mercy and Truth Medical Ministries
Kiowa: Kiowa County Memorial Clinics
Leavenworth: St. Vincent Clinic (Cerner)
Linn: Mercy Health System
Lyon: First Hits Community Health Center
Montgomery: Mercy Health System
Montgomery County Community Clinic
Pawnee: We Care Project
Pottawatomie: Community Health Ministry
Rawlins: Rawlins County Health Department
Reno: Prairie Star Community Health Center
Riley: Riley County-Manhattan Health Department
Saline: Salina Family Healthcare
Sedgwick: Center for Health and Wellness
E.C. Tyree Health and Dental Clinic
Good Samaritan Clinic
Grassroots Health and Dental Clinic
Guadalupe Clinic
Healthy Options Clinic
Hunter Health Clinic
Seward: United Methodist Mexican-American Ministries
Shawnee: Mercy Clinic
Shawnee County Health Agency
Wallace: Wallace County Family Practice
Wyandotte: Duchesne Clinic (Cerner)
Mercy and Truth Medical Missions
Silver City Health Center
Southwest Blvd. Family Health Care
Swope Health Services
Turner House Children's Clinic
*Statewide: Kansas Statewide Farmworker Health Program

10

Medicaid Dental Providers in Kansas

2009 State-funded Dental Clinic Sites by County



Barton: Via Care Project
Cherokee: Community Health Center of Southeast Kansas
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Douglas: Health Care Access
Finney: United Methodist Mexican-American Ministries
Geary: Konza Prairie Community Health Center
Harvey: Health Ministries Clinic (Look-Alike)
Johnson: Health Partnership Clinic of Johnson County
Lyon: Flint Hills Community Health Center
Pottawatomie: Community Health Ministry
Reno: PrairieStar Community Health Center
Saline: Salina Family Healthcare
Sedgwick: Center for Health and Wellness
E.C. Tyree Health and Dental Clinic
GraceMed Health and Dental Clinic
Healthy Options Clinic
Hunter Health Clinic
Shawnee: Marian Clinics
Wyandotte: Southwest Blvd. Family Health Care
Swope Health Services
***Statewide:** Kansas Statewide Farmworker Health Program

★ State-Funded FQHC or Look-Alike
● State-Funded Clinic

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Coordination of Care Initiatives in Kansas

- Medical Home
- Health Information Technology/Exchange
- Telemedicine/Telehealth

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Coordinating health & health care for a thriving Kansas

KHPA
KANSAS HEALTH POLICY AUTHORITY

2009 Health Reform Priorities

Statewide Clean Indoor Air

- Smoking is the number one preventable cause of death in Kansas. Each year, tobacco causes over 4,000 Kansas deaths, including 290 deaths attributable to second-hand smoke.
- Tobacco generates nearly $930 million in health care costs annually.
- If the current trend continues, 54,000 Kansas youth are projected to die from smoking.
- 83% of Kansans believe smoking is a serious health hazard.
- At least 36 states, including neighboring states, have imposed restrictions on smoking in public places.

Increased Tobacco User Fees

- A 10% increase in the price of a pack of cigarettes is associated with a 4% drop in tobacco use.
- Half of all Kansas smokers started smoking before the age of 14. Among teens, a cigarette price increase has been shown to result in a 7% reduction in smoking.
- The current excise tax on a pack of cigarettes in Kansas is $.79 but tobacco use costs Kansans the equivalent of $.86 per pack of cigarettes sold to pay for the tobacco-related illnesses of Medicaid recipients alone. KHPA recommends increasing the tobacco user fee by $.75 per pack, which would provide approximately $48.7 million in revenues in fiscal year 2010.

Increased Access to Affordable Health Care & Health & Wellness

- Medicaid for Poor Parents: KHPA recommends expanding Medicaid to include parents earning up to federal poverty level, $1,467 per month for a family of three.
- Improving access to affordable health insurance for small businesses and young adults.
- Implementing a statewide Community Health Record.
- Providing additional funding for breast and cervical screening, and expand the program to include screening for prostate and colorectal cancer to prevent illness and death from failure to timely detect those diseases; expanding the coordinated school health program; providing wellness grants for small businesses.
- Providing tobacco cessation programs for Medicaid recipients.

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Medical Home-Key Elements

- Team approach to care
- Registries for the top few diagnoses
- Active care coordination
- Prospective data collection
- Partnership with community resources
- Advanced patient education and self management support

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How Will I Know One When I See One?

- Commitment to care for the whole person
- Demonstrated use of tools and systems including registries and eventually EHR
- New NCQA medical home recognition program (PPC)
- Patient satisfaction and health outcomes

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PCMH-PPC Proposed Content and Scoring

Standard 1: Access and Communication	Pt
A. Has written standards for patient access and patient communication**	4
B. Uses data to show it meets its standards for patient access and communication**	5
	9

Standard 2: Patient Tracking and Registry Functions	Pt
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	6
E. Uses data to identify important diagnoses and conditions in practice**	4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pt
A. Adopts and implements evidence-based guidelines for three conditions **	3
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pt
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	4
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	7
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	4
	4

Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	3
B. Survey of patients' care experience	3
C. Reports performance across the practice or by physician **	3
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

** Priority Elements

Senate Bill 81: Defining Medical Home

- "a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventative care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner."

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Operationalizing Medical Home

Goal: Create a medical home model(s) for Kansas through payment reforms

- Technical Support: through State Quality Initiative (RWJ/Academy Health) – Kansas work plan
- Kansas All Stakeholders Group:
  - Principles subgroup
  - Pilot Projects subgroup
  - Communications subgroup
- Challenge: *How to leverage federal stimulus dollars to advance Medical Home?*

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Health Information Technology (HIT) & Health Information Exchange (HIE)

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Importance of HIT/HIE

- Need for Health Information Exchange/ Health Information Technology (HIE/HIT)
  - Promote coordination of care
  - Improve quality of care
  - Improve patient safety
  - Potential for achieving long term cost savings
- HIT/HIE fosters coordination of care and implementation of medical home model of care

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Improving Quality through Health Information Technology

"If we want safer, higher quality care, we will need to have redesigned systems of care, including the use of information technology to support clinical and administrative processes…the current care systems cannot do the job. Trying harder will not work. Changing systems of care will"

Crossing the Quality Chasm, Institute of Medicine

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Federal HIT/HIE Initiatives

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HIT/HIE at the Federal Level

- President Bush placed a significant focus on HIT/HIE Initiatives
- Created the Office National Coordinator for Health Information Technology (ONCHIT) in 2004
- Call for widespread adoption of Electronic Health Records (EHR) by 2014
- President's Aug 2006 Executive Order requiring Government departments and agencies involved in health care to adopt HIT standards

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Obama: American Recovery and Reinvestment Act (ARRA)

Policy Changes in ARRA

- Federal interoperability standards by 2010 that allow for the nationwide electronic exchange and use of health information
- Strengthens federal privacy and security law to protect from health information misuse

Financial Incentives

- $2 billion in competitive grants for HIT infrastructure; $1.5 billion for FQHCs
- Investing $17 billion for Medicare and Medicaid incentives to encourage doctors and hospitals to use HIT to electronically exchange patients' health information.

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History of Kansas HIT/HIE Initiatives

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Progression of HIT/HIE in Kansas

Governor's Health Care Cost Containment Commission (H4C)
November 2004

⇩

Kansas HIT/HIE Policy Initiative
Fall 2005

⇩

Kansas HIE Commission
March 2006

⇩

E-Health Advisory Council
(Advisory to KHPA Board and Governor)
Spring 2008

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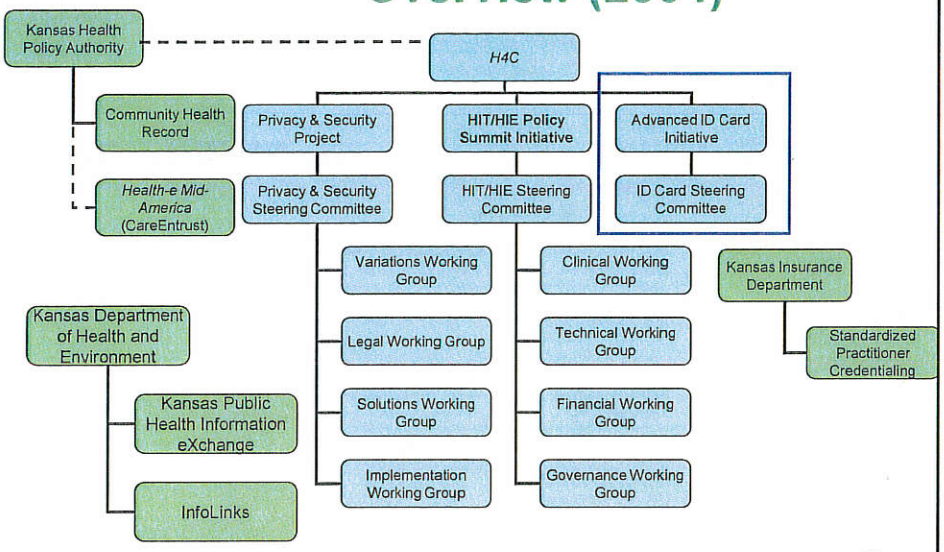
Kansas HIE Initiatives Overview (2004)



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Kansas: Health Care Cost Containment Commission (H4C)

- **History:** Established in November 2004 by Gov Sebelius, under direction of Lt. Gov John Moore
- **Charge:** Recommend solutions to improve patient care and lower costs by (1) reducing duplicative and inefficient administration processes and (2) developing strategies for efficient and effective use of health information
- **Results:** Development of a statewide shared vision for HIT/HIE – the "HIE Roadmap"

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HIT/HIE Policy Initiatives: Roadmap

- **Charge:** Develop shared vision for adoption of HIT & interoperability in KS; draft set of key principles & high level actions for statewide E-Health Information strategy
- **Work Groups:** Make recommendations on HIE infrastructure
  - **Governance:** develop sustainable governance model (oversight, coordination, direction)
  - **Clinical:** recommend data elements to be exchanged
  - **Technical:** assess HIE capability, identify gaps/barriers to address
  - **Financial:** develop sustainable financial model for infrastructure development and ongoing HIE
  - **Security and Privacy:** (Health Information Security and Privacy Collaboration or "HISPC") – develop implementation plan to address barriers to interoperable HIE
- **Financial Support:** Sunflower Foundation, United Methodist Health Ministry Fund, Kansas Health Foundation, and Kansas Health Policy Authority

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Kansas Roadmap & Progress

- Create public-private coordinating entity: *E-health Advisory Council*
- Provide stakeholder education: *Kansas Health Online*
- Leverage existing resources: *KHPA has two ongoing Health Information Exchange (HIE) pilots: Sedgwick County (Medicaid managed care); KC Metro Area (state employees)*
- Demonstrate impact of HIE and foster incremental change: *HIE pilots; challenges re: interoperability, sustainable funding, ROI*
- Address privacy and security barriers: *Kansas HISPC Project (I, II, and III)*
- Seek funding from multiple sources: *Request for SGF in FY 09 and FY 2010; looking for foundation support for HIT/HIE and medical home model of health care delivery*

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Core Team Project

Health Information Exchange Commission (HIEC)

- **History:** Governor's Executive Order established the Commission Feb, 2007
- **Charge:** To serve as a leadership and advisory group for HIE/HIT in Kansas
- **Results:**
  - Report of the HIEC delivered to the Governor for her consideration
  - HIEC Recommended:
    - Establishment of a public/private coordinating entity
    - Resource support for HIT/HIE efforts in Kansas

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E-Health Advisory Council

- **History:** Given KHPA's statutory charge to coordinate health care for Kansas, Governor requested KHPA to guide development and administration of statewide health information technology and exchange
- **Charge:** E-Health Information Advisory Council reports to Governor and KHPA, focus on:
  - Statewide Community Health Record
  - Develop and implement resource center for providers wishing to implement HIT/HIE
  - Develop policy recommendations to advance HIT/HIE in Kansas

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Statewide Community Health Record

- Health Information Technology and Exchange:
  - Facilitate sharing, exchange of health records
  - Promote safety and improve quality
  - Improve efficiency and promote cost savings
- Two ongoing pilot projects
  - Wichita: HealthWave managed care providers
  - KC Area: State employees participating in employer sponsored initiative
- Expand statewide for Medicaid and SEHP
- Budget Impact FY 2010: $1,096,000 (AF); $383,600 (SGF)

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Kansas Medicaid Community Health Record (CHR)

- **Location:** Sedgwick County, KS
- **Pilot Population:** Medicaid Managed Care
- **Purpose:** To improve the quality, safety, and cost-effectiveness of care
- **Timeline:**
  - Launched in Feb 2006
  - Currently implemented in 20 sites
  - Submitted a budget enhancement request of $50,000 SGF for FY 2009 to expand program to 20 additional sites in Sedgwick County
  - Statewide expansion included in KHPA Board health reform recommendations for 2008 legislative session

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CareEntrust: Kansas City Health Exchange

- **Location and Participants**: Non-profit organization comprised of around 20 of Kansas City's leading employers and health care organizations including Kansas State Employee Health Plan (for KC residents)
- **Purpose:** To develop and manage the CHR as a means to improving patient safety and avoiding costly and wasteful health care practices
- **Timeline:** Developed a business plan for a Regional Health Information Exchange that governs and manages a CHR for Wyandotte, Leavenworth, and Johnson Counties – Kansas SEHP beginning this month

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Health Information Security and Privacy Collaboration (HISPC)

- **Funding:** Federal Health and Human Service Grant funded through RTI International
  - Partnership with the National Governor's Association
- **Purpose:** Statewide assessment of business practices and policies around HIE; identify barriers to interoperable HIE; develop solutions
- **HISPC I, II, and III in Kansas:**
  - Sponsored by Governor's Health Care Cost Containment Commission (H4C); Kansas one of 34 states awarded subcontract
  - **Public-Private Project Team:** KHI – project manager, KU Center for Health Informatics, and KHPA, Mid-America Coalition on Healthcare, Lathrop & Gage, other stakeholders
  - **Developed Tool to Assist States Harmonize Privacy Laws**

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Numerous Other Projects

- Central Plains Regional Health Care Foundation – Clinics Patient Index
- Community Health Center (Health Choice) Project
- Jayhawk Point of Care (POC)
- Northwest Kansas Health Alliance
- Kansas Public Health eXchange (PHIX)
- Kansas City Quality Improvement Consortium
- KAN-ED
- Other Projects: Rural Outreach, KC Carelink, KC Bi-State Health Information Exchange

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Tying it all together

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Future of these Initiatives

- **Through ARRA, role for federal leadership re: interoperability and privacy protections**
- State of Kansas:
  - Well positioned to develop plan for federal funding given work of the Governor's Cost Containment Commission, the Kansas HIE Commission, the Health Information Security and Privacy Collaboration, E-health Advisory Council, and myriad others
  - **Goal: Improve coordination of care of health outcomes**
    - Incentivize the use of electronic health information, HIE, telemedicine, etc
    - Leverage these resources consistent with a medical home model of care delivery

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Federal HI TECH Act

- HIT/HIE provisions of ARRA
- HITECH: Health Information Technology for Economic and Clinical Health Act
- Create Kansas HITECH Plan –
  - Merge efforts of various initiatives (both HIT/HIE and medical home) into comprehensive plan
  - Determine list of "shovel ready" projects appropriate for funding
  - Bring stakeholders together to determine priorities and get to work

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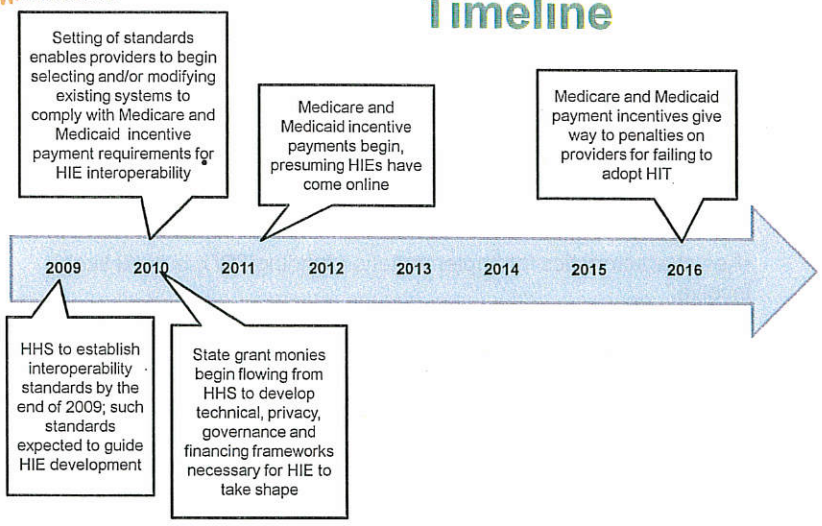
Aligning KS HITECH Plan

Federal Interoperability Standards	Health Information Privacy and Security	$2 B in Grants and loans to purchase HIT ; $1.5 B for FQHCs	Payment incentives in Medicaid/Medicare for EHR
Kansas standards team to monitor federal work to ensure alignment – providers will benefit from federal inoperability standards that will ease health information exchange – select team to	Kansas HISPC team can be integrated into KS HITECH plan via development and implementation of state harmonization laws and rural consumer education	Kansas grant team to develop funding priorities from list of shovel ready projects that promote medical home model of care or follow specifics of ARRA federal funding guidelines (not yet published)	Kansas payment incentives team to track rules and regulations for increased provider reimbursement for those providers utilizing electronic health information and provide education for interested providers

Timeline



Funding Mechanism Appropriations, subject to annual review & authorization	**Payment Agent** States or state-designated entities
Payment Recipients •State Department of Health or a qualified state-designated HIE governing entity. •Recipients must consult with wide range of stake holders throughout health care.	**Level of Funding** •At least $300 million in grants to be divided among planning & implementation activities. •State matching funds may be required in FY 09 & 10 (and will be required in FY 11)
Requirements for Funding •Submission of a plan, approved by HHS, that describes the activities to facilitate and expand the electronic movement and use of HIE according to nationally recognized standards and implementation specifications.	
Use of Funds •Enhancing broad and varied participation in nationwide HIE •Identifying State or local resources available towards a nationwide effort to promote health IT •Complementing other federal programs and efforts towards the promotion of health IT •Providing technical assistance to develop & disseminate solutions to advance HIE •Promoting effective strategies to adopt and utilize health IT in medically underserved communities •Assisting patients in utilizing health IT •Encouraging clinicians to work with Health IT Regional Extension Centers •Supporting public health agencies' access to electronic health information •Promoting the use of EHRs for quality improvement	

Consideration

•HIE provision distinguishes between planning an implementation grants, and it is likely that much larger grants will go toward implementation.

•Key characteristics for implementation funding TBD, but will likely involve:

- –An operating governance structure
- –A defined technical plan
- –Defined clinical use cases
- –Statewide policy guidance as to privacy and security

•There is an implicit onus on States to develop HIE infrastructure in the near-term to enable otherwise-eligible providers to earn their Medicare/Medicaid incentive payments.

	Medicare	Medicaid
Funding mechanism(s)	Incentive payments	Incentive payments, State matching payments (administrative costs)
Payment Agent	Medicare carriers and contractors	State Medicaid agencies
Payment Recipients	Hospitals and physicians	Hospitals and physicians; State Medicaid agencies for administration
Amounts for Hospitals	$2 million base amount	For eligible Acute Care & Children's hospitals…limited to amount calculated under Medicare, by Medicaid share
Amounts for physicians and other health professionals	May receive up to $41,000	In aggregate, an eligible professional may receive up to 85 percent of $75,000 over a five year period.
Key Consideration	*Hospitals will qualify for both Medicare and Medicaid dollars (unlike professionals) but will be forced to participate in HIE projects and be "meaningful user" to drawn down funds*	

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Testimony to Kansas Senate Public Health and Welfare Committee
Kansas Work and Accomplishments in the Health Information Security and Privacy Collaboration

Submitted by:

Helen R. Connors, PhD, RN, FAAN, Chair, HISPC Steering Committee
Jeffrey O. Ellis, JD, Chair, HISPC Kansas Legal Work Group
Julie A. Roth, MHSA, JD, RHIA, Member, HISPC Kansas Legal Work Group

Background

In June, 2005, the U.S. Department of Health and Human Services published the "Summary of Nationwide Health Information Network Request for Information Responses." The Summary showed that individuals and organizations were strongly concerned about the privacy and security of health information in a nationwide health information network. Concern was also expressed about the varying applications and interpretations of the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security rules, and the impact of those varying interpretations on a nationwide electronic health information exchange. Inconsistencies among state and federal privacy laws were also cited as a complication in the potential for electronic health information exchange.

The Health Information Privacy and Security Collaboration (HISPC) was established in 2006 through a grant funded by the Agency for Healthcare Research and Quality. The purpose of the Collaboration is to assess the variations in organization-level business practices, policies, and state laws that affect electronic health information exchange and to identify and propose practical ways to reduce the variations in practices, permitting interoperability while preserving necessary privacy and security requirements. The project has been administered and three phases, and is managed by RTI International.

In 2006, Kansas was awarded funding to join HISPC, along with 32 other states and the territory of Puerto Rico. The Healthcare Cost Containment Commission (H4C) designated the Kansas Health Institute to administer the subcontract with RTI International. A Steering Committee and four work groups (the Variations Work Group, the Legal Work Group, the Solutions Work Group, and the Implementation Work Group) were established to oversee and manage the Kansas HISPC work.

HISPC Phase I

During the first phase of the contract, the Kansas HISPC team (the Steering Committee and members of the Work Groups) were charged with establishing a long term plan for accomplishing the following overall project outcomes: Stakeholders, including state entities, were to develop a full understanding of variations in business and

privacy and security policies and practices; States, thorough use of stakeholder groups, were to design practical solutions and implementation plans for preserving privacy and security protections while implementing electronic health information systems; and Long-lasting collaborative networks were to be established for states and communities to support future work.

The Kansas HISPC team developed a Kansas-specific long-term plan to implement the overall objectives of the project. The plan included establishing a statewide coordinating entity to play the important role of facilitating health information exchange within the state and continuing work with the HISPC team. To eliminate confusion regarding varying interpretation of laws, the plan called for a coordinated interpretation of Kansas and federal laws pertaining to the exchange of health information. Similarly, the plan also called for common health informatics standards and best practices to improve the exchange of health information and monitor the evolution of national platforms. Finally, the plan included the development of model policies, procedures, and guidelines for health information exchange; education for health care entities and the public about the benefits and processes of health information exchange; and the general promotion of the implementation of health information exchange.

HISPC Phase II

In HISPC Phase II, which began in June, 2007, funding was made available to help HISPC states to organize in multi-state collaborative around common goals and to submit collaborative projects for HISPC III. [1] The Kansas team selected to participate in two multi-state collaborative planning groups: 1) the Harmonizing State Privacy Laws Collaborative (HSPLC); and 2) the Consumer Education and Engagement Collaborative (CEEC). The HSPLC was formed to support the implementation of both intrastate and interstate electronic health information exchange by assisting states in identifying, analyzing and reforming their laws as they relate to the adoption of health information technology. It consists of Kansas, Missouri, Texas, Kentucky, Florida, New Mexico, and Michigan. The CEEC was formed to advance multi-state efforts in the area of educating consumers and engaging them in the implementation of health information exchange. The CEEC consists of Kansas, Colorado, Georgia, Massachusetts, New York, Oregon, Washington, and West Virginia.

Harmonizing State Privacy Laws The Kansas HISPC team established the goal of completing the first phase of a long term review of Kansas statutes and administrative regulations relevant to health information security and privacy. To undertake this enormous task, a tool was designed to facilitate the collection and later analysis of privacy law. Using the tool, the Kansas Legal Work Group, which consists of both private and public sector attorneys, conducted a survey of Kansas law to identify statutes and regulations involving the disclosure of health information. The Legal Work Group

[1] Collaboratives Include: Consent 1 (Data Elements), Consent 2 (Policy Options), Harmonizing State Privacy Law, Consumer Education and Engagement, Provider Education, Adoption of Standards and Policies, and Inter-organizational Agreements

then identified those laws that specifically related to privacy, and conducted a preliminary analysis of the privacy laws' relationship to HIPAA.

Through this process, the Legal Work Group determined that Kansas health information laws are decentralized and scattered across numerous statutory and regulatory structures, and that Kansas law does not provide a cohesive structure to support widespread electronic health information exchange. The Legal Work Group also determined that this lack of cohesive legal structure creates a barrier to the broad use of technological advancements supporting the appropriate and secure collection, use, and exchange of health information in Kansas. The Legal Workgroup developed the Draft Resolution, attached to this testimony, as a potential tool to use in laying the groundwork for the secure and appropriate exchange of health information.

Consumer Engagement and Education The Consumer Education and Engagement work group recognized that consumer interests, preferences, knowledge and attitudes are central to successful health information exchange, and established the goal of convening a stakeholder group to develop a content outline for a tool kit (*e.g.* curriculum outlines, teaching strategies, outreach plans, etc.) for educating stakeholders about the electronic exchange of health information. The curricula focused on privacy and security issues and the state and federal laws governing the exchange of health information. The targeted focus group for the Kansas project was rural consumers. The specific educational materials and took kit itself were to be developed in Phase III.

HISPC Phase III

HISPC III, which began in April, 2008, has focused on interstate collaboration to create tools and resources that are adaptable and useful to all states.

Harmonizing State Privacy Law Using the tool developed by Kansas Legal Work Group, as well as resources gathered from other states, HSPLC has developed two tools: Comparative Analysis Matrix (CAM) and Assessment Tool. The CAM is a collection of almost 150 subject-matter areas typically addressed in state law that involve or may impact the disclosure of health information. The CAM is designed to facilitate comparison and analysis of state laws by providing the framework for consistent and structured review processes. The Assessment Tool is designed to assist stakeholders in identifying priority recommendations for legislation. It is intended to facilitate discussion about a recommendation's impact on patient and population health and privacy protection, as well as ease of reaching a consensus. Screen-shots of the CAM and Assessment Tool are attached. Other resources developed by the HSPLC include a "Roadmap" that describes how to use the CAM and Assessment Tool as well as the Collaborative's experiences and recommendations for facilitating a health information exchange legal framework.

Consumer Education and Engagement The CEEC has developed a glossary of health information technology and health information exchange terms and has accumulated an inventory of teaching materials designed to educate consumers about electronic health information exchange. The Kansas CEEC targets residents of rural

Kansas, and has identified rural consumers' health information exchange and technology privacy and security education needs and solicited feedback on preferences in regards to dissemination of messages. The team has developed a communication plan to disseminate the targeted messages about health information exchange and health information technology privacy and security to consumers as well as a plan to evaluate the impact of the health information technology and health information exchange privacy and security education materials on knowledge and attitudes of consumers in rural Kansas, and document lessons learned. Additionally, the group is making an educational toolkit available, which includes the work of each state in the collaborative in addition to the Kansas specific tools. The materials currently available on the University of Kansas Center for Health Informatics Web site[2] and will ultimately be available on an ONC Web portal.

Conclusion

We appreciate the opportunity to provide you with this testimony about the work and accomplishments that Kansas has achieved in the Health Information Security and Privacy Collaboration. We submit that the accomplishments made through HISPC provide the State with a mechanism to analyze state law and regulations through the CAM and Assessment Tool, as well as a blueprint for educating Kansas consumers and providers regarding the value of health information exchange and methods to facilitate its implementation. We stand ready to assist you and the State of Kansas in creating an environment that facilitates health information technology and exchange.

[2] http://www2.kumc.edu/healthinformatics/HISPC/hispc.htm/

HISPC Deliverables

- Harmonizing State Laws
    - Resolution
    - CAM and Assessment Tool
    - Roadmap (3/31/2009)
- Consumer Education and Engagement
    - Summary report of consumer needs and preferences (7/30/08)
    - Communication Plan (2/15/09)
    - Evaluation Plan and Lessons Learned (3/31/09)
    - Final Toolkit for educating consumers (3/31/09)

Chapter __

SENATE CONCURRENT RESOLUTION No. __

A CONCURRENT RESOLUTION approving . . .

WHEREAS, Individuals of this State have the primary interest in the confidentiality, security, integrity, and availability of their health information;

WHEREAS, The availability, quality and efficiency in the delivery of health care, including establishment of medical homes, depend upon the efficient and secure collection, use, maintenance, and exchange of health information;

WHEREAS, The use of current and emerging technology facilitates the efficient and secure collection use, maintenance and exchange of health information; and

WHEREAS, The State's antiquated and decentralized statutory and regulatory scheme, and its interaction with federal mandates, creates confusion and is a significant barrier to the efficient and secure collection, use, maintenance, and exchange of health information.

Be it resolved by the Senate of the State of Kansas, the House of Representatives concurring therein: That the laws of this State should be reviewed, modified as necessary, and construed to protect the interests of individuals in the confidentiality, security, integrity and availability of their health information; to promote the use of modern technology in the collection, use, maintenance, and exchange of health information; to promote uniformity in policy; and to codify all standards in a cohesive and comprehensive statutory structure.

	Combined Comparative Analysis Matrix (CAM)				
			More Stringent than HIPAA for		
	Subject Matter	Citation/ Link	Patient Care?	Population Health?	References to Related State/ Federal Law & Legislative Proposals
118		NM: health care information NMSA 1978 § 24-7B-10	N	N	
119	Age Consent requirements - other conditions	FL: FS 743.06 Blood Donation, FS 743.065 Care of minor child	N	N	
120		TX: Fam Code 32.002-004	Y		
121		KY: KRS 214.185; KRS 222.441	N	N	
122		KS: 38-122			
123		MI: Public Health Code (MCL 333.17015: Informed consent for abortion) Marriage License (MCL 551.103: Persons capable of contracting marriage; age requirement; etc.)			
124		MO: 431.061			
125	**Patient Proxies**				
126	Personal Representatives/Executors	FL: FS 731.201(27)	N	N	
127		TX: Various Probate and HR Code sections	Y		
128		KY: KRS 395 passim	N	N	
129		KS: 58-654			
130		MI: Medical Records Access Act (MCL 333.26263: Definitions)			
131		MO: 473.110, 473.113, 473.117			
132	Guardians	FL: FS Ch. 744	N	N	
133		TX: Various sections of Human Resources Code	Y		
134		KY: KRS 387.590 (10)	N	N	
135		KS: 59-3075			
136		MI: Medical Records Access Act (MCL 333.26263: Definitions)			
137		MO: 475.075, 475.082, 475.120, 630.140, 632.175			
138	Health Care Power of Attorney	FL: FS Ch. 765	N	N	
139		TX: H&S Code 166	Y		
140		KY: KRS 311.629	N	N	
141		KS: 58-625			
142		MO: 404.840			
143		MI: Estates and Protected Individuals Code (MCL 700.5501: Durable Power of Attorney; definition)			
144		NM: NM Uniform Health Care Decisions Act NMSA 1978 § 24-7A-1 et seq.	N	N	
145	Health Care Power of Attorney - mental health	FL: FS 765.202(5)	N	N	
146		TX: H&S Code 166	Y		

Sample Screen Shot of Assessment Tool

HSPLC CAM and Assessment Tool							
	Facilitates HIE Development (Based on the state's current HIE development, how significant is this?)	Ease of Reaching Consensus Among Stakeholders (e.g., cultural/ regional attitudes, economic impact, non-state after-effects)	Positive Impact on Patient-Focused Health Care	Positive Impact on Population Health	Effect on Consumer Privacy Protection (maintains appropriate consumer privacy protection)	TOTAL Optional	Comments
	1=Little Effect 3=Neutral Effect 5=Significant Effect	1=Difficult to change 3=Neutral 5=Easy to change	1=Little Effect 3=Neutral 5=Significant Effect	1=Little Effect 3=Neutral 5=Significant Effect	1=Reduces 3=Neutral 5=Enhances		
Subject Matter							
Age Consent requirements - other conditions							
Patient Proxies							
Personal Representatives/ Executors							
Guardians							

KANSAS HOSPITAL ASSOCIATION
Tom Bell
President and CEO

To: Senate Public Health and Welfare Committee

From: Tom Bell
President and CEO

Date: March 2, 2009

RE: Health Information Technology Provisions of the American Recovery and Reinvestment Act

On February 17, President Obama signed into law the American Recovery and Investment Act (ARRA), which contains many provisions designed to move the country closer to the goal of a modernized health care delivery model enabled by information technology. The vision includes greater efficiency through reduced paperwork, the elimination of duplicative or unnecessary testing and increased capacity to provide better decision support at the point of care.

The ARRA also codifies the Office of the National Coordinator for Health Information Technology (ONCHIT) and outlines a standards development and certification process for electronic health record (EHR) systems that will further reduce risk for providers. The cost of implementing information technology has long been considered a primary obstacle to greater adoption, and the ARRA provides substantial incentive payments for physicians and hospitals to adopt health information technology for the first time, or to further advance the capabilities of their existing systems.

The ARRA makes Medicare incentive payments available to acute-care prospective payment system (PPS) hospitals and Critical Access Hospitals (CAHs). A hospital is eligible for Medicare incentives if it demonstrates that it is a "meaningful user of certified EHR technology," which will be determined by the Secretary of the Department of Health and Human Services. Methods to determine whether an organization qualifies as a "meaningful user" may include provider attestation, submission of claims with an additional code, survey responses, quality reporting or other means. Demonstrating that an organization is a "meaningful user" also may include proving that certified electronic health record (HER) technology is connected in a manner that provides, according to law and standards, for electronic exchange of health information to improve the quality of care and improve care coordination. Hospitals also will be required to submit clinical quality measures and other measures selected by the Secretary, but will not be required to do so unless the Secretary can receive such reports electronically.

Kansas Hospital Assoc
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PPS hospitals that are meaningful users of EHR are eligible for incentives beginning in fiscal year 2011 and can receive payments for up to four years. The ARRA details the formula that the Centers for Medicare & Medicaid Services must use to pay the incentives. However, penalties will be imposed on the PPS hospitals unless a significant hardship is demonstrated. Hospitals that are not meaningful users by FY 2015 will see their market basket update reduced. Adoption in later years can prevent the update reductions, but no incentive payments would be available.

The ARRA creates a different payment incentive for Critical Access Hospitals (CAHs). These payments build off of the current cost-based payment system that pays CAHs 101 percent of their Medicare allowed costs. Under the incentive, a CAH that is determined to be a meaningful user can fully depreciate certified EHR costs beginning in FY 2011. Similar to PPS hospitals, CAHs may be penalized unless significant hardship is demonstrated. CAHs that have not implemented EHRs by FY 2015 are subject to payment reductions. However, CAHs may only receive a hardship exemption for a maximum of five years.

While there still are several questions that remain regarding the HIT provisions in the ARRA, KHA believes that the passage of this legislation should encourage adoption of health information technology. Attached to our testimony is a set of frequently asked questions that KHA developed to share with its members. KHA stands ready, and willing, to work with the Kansas legislature, Kansas Health Policy Authority and other interested stakeholders in setting the technological course for the state of Kansas.

Thank you for your consideration of our comments.

American Economic Recovery and Reinvestment Act of 2009 (ARRA) Health Information Technology (HIT) Provisions

Frequently Asked Questions
Updated February 23, 2009

Questions:

1) What are the basic HIT related provisions in the ARRA?

KHA has developed a top line summary of all the hospital related provisions of the ARRA which can be found on the KHA Web site.

While the HIT provisions are only a small portion of the total funds authorized in the ARRA, they have a tremendous impact on Kansas hospitals. In general, Title VIII of the ARRA (also referred to as the HITECH Act) established the basis for a national system of health information exchange. The ARRA includes a number of provisions of direct interest to hospitals:

- Charges the Secretary of Health and Human Services (HHS) and its newly codified Office of the National Coordinator for HIT (ONC or ONCHIT) specifically with developing and implementing a strategic plan along with developing standards, expanding infrastructure and distributing funds for HIT adoption and specifically achieving health information exchange.
- Directs the Secretary and the ONC to establish advisory committees on policy and standards that are representative of key interests and establishing a Privacy Director position within the ONC.
- Funds states, HIT/HIE initiatives and providers for technology proliferation and adoption.
- Penalizes hospitals and physicians for not meeting the implementation target dates.
- Adds requirements for assuring privacy and security of electronic health records and information.

3-3

Much is left to the discretion of the Secretary of Health and Human Services, a position that is yet to be filled and confirmed. The ONC has developed a strategic plan which will undoubtedly be used to direct initiation policy.

2) What is the general time frame of the legislation?

- 2009 -- funding for ONCHIT, standards development, regional support structures, application process for state grants.
- 2010 -- state grants and loan programs.
- 2011-2014 -- implementation of incentives for hospitals and physicians.
- 2015 -- implementation of penalties for hospitals.
- 2015 -- implementation of penalties for physicians.

3) When will the certification process, as well as standards related to content and interoperability be available to providers and vendors?

An initial set of standards is required by December 31, 2010. Representatives of the ONC have indicated that standards in both areas are actually drafted and being tested by vendors now. The CCHIT Web site has the details of these draft standards. The goal of the current ONC is to formally publish these standards in April of 2009. However, under the new law, the Secretary of HHS must formally adopt the standards and that position has not yet been filled. While the new administration will undoubtedly use the work of the ONC to date, policy and direction may change.

4) How much money was appropriated?

The legislation appropriated $19 Billion toward the HIT related provisions. In general, $2 billion will go to HHS and the ONC to support competitive grants for governmental, regional, state and local infrastructure and support systems. In addition, these funds are to support initiatives in telemedicine and integration of HIT into clinical education. The remaining $17 billion are for Medicare and Medicaid incentive payments to hospitals, physicians and other providers of healthcare to adopt HIT and participate in HIE.

5) How much money will Kansas receive?

Generally speaking, Kansas receives about 1% of federal funds that get distributed to states. However, much of the grant program language in ARRA requires that states apply for these funds. In addition, while HHS is authorized to set up state-based loan programs, the language is permissive, not directive.

The distribution of payments to individual hospitals will be dependent on the circumstances of the hospital. KHA has provided a tool to member hospitals to assess individual hospital impact. For more information contact KHA.

6) How will the funds flow?

HHS is charged to work with a number of federal agencies to distribute and utilize these funds. Some of the funds remain at the national level to develop the administrative capacity and establish a new HIT Research Center and regional centers. Most of the grant funds will be distributed in response to applications from a "state designated agency." Provider payments will be distributed directly from CMS for Medicare and the state Medicaid agency which, in Kansas, is the Kansas Health Policy Authority.

7) What is the role of the state of Kansas?

The state will be responsible for applying for grant funds directly or designating an entity or entities to apply on behalf of the state. Even though there are a number of initiatives in Kansas focusing their energies in the realm of HIT and health information exchange, most believe that the Kansas Health Policy Authority is the logical governmental entity.

In addition, Kansas will be responsible for distributing funds to providers through the Medicaid program. The Kansas Health Policy Authority will be directly responsible for this function.

8) What is the state of Kansas doing to prepare?
The Lieutenant Governor has convened a group of cabinet secretaries, agency heads, legislative leaders and other state leadership, including the Kansas Health Policy Authority, to prepare to meet state requirements for receiving and distributing the funds. KHPA has been assigned to track and plan strategies related to the HIT components.

Staff of the KHPA is in the process of estimating the financial impact on the state of all of the health related provisions in the ARRA. KHPA is committed to formalizing a state HIT plan in sixty days which will build on work of previous initiatives. KHPA is working with stakeholders to align past work in Kansas with new guidance in the development of a strategic plan.

KHA has provided a tool to member hospitals to assess individual hospital impact. For more information contact KHA.

9) Are there any grants? How are the grants determined?
Grants, most of which are not available until 2010, are authorized in a number of areas:

- To providers of broadband to expand access.
- To established Health Information Exchanges to expand.
- To states to support planning and implementation of EHR and HIE in the state.
- To HIT expert organizations to provide research and technical support.

HHS *may* also provide funds to states to establish loan programs. Matching funds will be required, and the Secretary of HHS is not required to do this.

10) Who will receive the grant funds that are directed at HIT adoption in Kansas?
Planning grants will be provided to states or state designated entities who apply for these funds. Kansas has a number of groups who may vie to be the state designated entity. To qualify as a state designated entity, they must be non-profit with broad stakeholder representation on its board and submit an application describing plans for the expansion and use of HIT. It is unclear whether these funds will be allocated to states or distributed based on competitive applications. Kansas leadership is working under the premise that the grants will be competitive for early adopters. To date, the health related lead for this component is the Kansas Health Policy Authority and their E-Health Advisory Committee.

11) Who will receive funds for EHR adoption?
All hospitals will be eligible to receive Medicare funds along with non-hospital based physicians. Psychiatric, rehabilitation and long-term care hospitals are specifically excluded. In addition, increased federal matching funds will be available for payments to providers whose patient mix is at least 10% Medicaid. Payments may be made for purchase of certified EHR including training and maintenance. States will also be eligible for funding to assist in determining if providers are demonstrating "meaningful use" of EHR technology.

KHA has provided a tool to member hospitals to assess individual hospital impact. For more information contact KHA.

12) When will these funds be available?
Provider payments will begin in 2011. Grant and loan programs will be available as soon as rules and guidance are developed and after HHS adopts basic EHR standards due by the end of 2009.

13) How much funding can Kansas Community Hospitals expect to receive?
Every hospital is different depending on the size of its Medicare patient base and its progress toward EHR adoption. KHA has provided a tool to member hospitals to assess individual hospital impact. For more information contact KHA.

PPS hospitals begin with an annual flat amount which is a formula applying a hospital's "Medicare portion" of $2 million plus amounts per discharge beginning with the 1150th ending at 23,000 discharges. Each hospital is capped at $11 million. Payments will begin for hospitals initiating "meaningful" EHR adoption in 2011 and will be phased out over four years. Hospitals may begin this process in or after 2012, but will only receive a portion of the funding depending on the year they begin.

The incentive for CAH hospitals will be built into their cost based reimbursement. CAH hospitals will be allowed to expense the Medicare share + 20 percentage points of their hardware and software in one year rather than a traditional depreciation process.

14) What does "meaningful" adoption of EHR mean?
While specifics of this adjective have yet to be fully determined, characteristics of "meaningful" most often highlighted include:

- The use of a HHS/ONC certified EHR technology.
- That it includes key components such as decision support, physician order entry or, for physicians, e-prescribing.
- That the technology is connected in a way that improves care coordination and quality (some interpret this to mean involvement in health information exchange).
- That the technology collects and reports clinical quality measures to HHS.

More information on the Certification can be found on the Commission for Certification of Health Information Technology Web site. The Secretary of HHS is also charged with requiring more stringent measures for "meaningful" over time.

15) Do all Community Hospitals have to implement EHRs?
Yes. According to the language in the legislation, participation in the funding incentives is voluntary. However, if a hospital does not have a "meaningful" EHR in place by 2015, penalties will begin regardless of participation in the funding incentives. There are, however, hardship provisions for both PPS and CAH facilities.

16) What if we have already started adopting an EHR?
If you already have an EHR or are well down the road, you are in a prime position to make full use of payment incentives. Your vendors will be modifying software and, perhaps some hardware, to meet the standards as they become available. Cost for these modifications will be vendor specific.

17) What are the penalties?
PPS hospitals will see reductions in their market basket increase beginning in 2015. The first year of reduction will be a 25% reduction in two-thirds of the MB increase. The reduction will be increased to 100% over 4 years.

Medicare payments are reduced for CAHs that are not meaningful users of EHR starting FY 2015. Payment is reduced from 101 percent to 100.66 percent of cost in FY 2015, 100.33 percent of cost in FY 2016, and 100 percent of cost in FY 2017 and thereafter.

18) What health information exchange will be required for hospitals?
Much of this requirement remains unclear. HIE could mean as little as reporting quality data electronically to CMS and Medicaid (KHPA) to true provider-to-provider and provider-to-other (insurers, community and regional) exchanges. The current ONC has focused its initiatives to support regional exchanges. It's uncertain how a new administration's policy will impact this requirement.

19) How does this affect physicians?
Physicians are both a key component to hospital successful implementation of "meaningful" EHRs and a direct recipient of incentives and penalties for adoption of the technology in their practices. Full use and participation by physicians in the hospital technology will be critical to receipt of hospital incentives and the avoidance of

penalties. In addition, legislation articulates direct payments to non hospital-based physicians in the amount of 75% of their allowable Part B charges subject to an $18,000 first year cap and a $44,000 cumulative cap. Like hospital payments, physician payments are also phased down over 5 years.

Physicians are subject to penalties beginning in 2015 with a 1 percent reduction in their fee schedule accelerating to 3 percent in 2017 and future years.

20) What is the definition of a hospital-based physician?
Hospital-based physicians who furnish substantially all services in a hospital setting and use the facilities of the hospital and its equipment are not eligible for incentives under this legislation. Employment is not a factor in determining whether or not a physician is hospital-based. The determination will be dependent on site of service as defined by the Secretary.

21) What are the basic privacy and security provisions?
While there are a number of privacy and security provisions included in the ARRA, some of the key ones of interest to hospitals are:

- Patients (and, in some cases, HHS and the media) will have to be notified of unauthorized disclosures of protected health information (PHI).
- Individuals will be able to place additional restrictions on disclosure of their PHI.
- New rules for accounting of disclosures of electronic health records will be developed.
- Fundraising solicitations will have to include more "clear and conspicuous" opt-out notices.
- State Attorney Generals will be able to bring federal lawsuits against individuals who violate HIPAA.

22) What will KHA be doing to help KHA members understand and implement the HIT provisions?
Most importantly, KHA is working with its data analytic sources to provide members with hospital specific impact analysis. These analyses will be distributed to member hospitals as soon as they are available.

In addition, KHA Policy Groups, including the Health Information Technology Technical Advisory Group, Council on Health Delivery, and Council on Health Care Finance and Reimbursement are all providing input on their concerns, discussing strategies and providing guidance. Eight principle statements have been drafted around issues of state leadership, setting of priorities, national standards and enforcement, purposes of HIT, privacy and security, financial support, physician adoption and workforce impacts which will be discussed by the KHA Board and serve as the basis for advocacy.

Direct strategies to assist members directly and advocate for member needs include:

- Providing hospital specific and Kansas statewide impact analysis for local, state and national use. KHA has provided a tool to member hospitals to assess individual hospital impact. For more information about this tool, contact KHA.
- Educating state legislators and the Kansas Congressional Delegation about the complexity of the HIT provisions in the American Recovery and Reinvestment Act.
- Working with KHPA to develop the state plan for HIT and EHR adoption in Kansas.
- Communicating member concerns about vendor readiness and capacity to meet the demand and ability to provide necessary technical support to the market.
- Collaborating with state level physician groups to educate and encourage physician adoption.
- Exploring ideas and strategies to assure health information technical support is available to small rural hospitals in Kansas.
- Providing members with information about ARRA and related rules, regulation, and guidance promulgated to support HIT adoption, funding and penalties.

Links and Resources:

- ARRA Summary of Hospital Related Provisions
- Health and Human Services
- Office of the National Coordinator for HIT
- ONC Strategic plan
- KHPA E-Health Advisory Committee
- Hospital specific impact studies
- KHA ARRA resources
- Certification Criteria

The American Economic Recovery and Reinvestment Act of 2009
Conference Committee Agreement

Provision	Conference Committee Agreement Details Based on February 12, 2009 Agreement
Federal Medical Assistance Percentage (FMAP) **$86.7 Billion**	Temporary 6.2% increase for all states over nine quarters, beginning October 1, 2008 and expiring December 31, 2010. — FMAP increase does not apply to Medicaid Disproportionate Share Hospital (DSH) payments. — States are required to maintain eligibility levels.
Kansas Impact	Kansas will receive a total of $450 million over a 27 month period. What it means --- the state will be able to keep payment rates whole while spending less state dollars.
Medicare Inpatient Hospital Capital Indirect Medical Education (IME) Payments **$191 million**	Reverses 50% reduction to Medicare inpatient capital IME payments to teaching hospitals that went into effect on October 1, 2008 and blocks implementation of this reduction through the rest of the federal fiscal year (FFY) 2009. This provision does not block the full phase-out of these payments scheduled for October 1, 2009 (FFY 2010). The Secretary of the Department of Health and Human Services (HHS) has the authority to reverse the cut administratively.
Kansas Impact	Kansas teaching hospitals will receive an additional $945,000 for FFY 2009
Moratoria on Bush Medicaid Regulations **$100 million**	Extends for three months, until July 1, 2009, an existing moratorium on three Medicaid regulations: • provider taxes • school-based health • targeted case management • Medicaid hospital outpatient department and clinic rule (implemented on 12-8-08)_ Encourages the Secretary not to promulgate three regulations currently under a moratorium set to expire on April 1, 2009:

	• Intergovernmental transfers and certified public expenditures (IGT and CPE) • Graduate Medical Education (GME) • Rehabilitation services
Kansas Impact	Will allow Kansas to continue current IGT and CPE program thereby saving substantial State General Fund dollars. Impact of Medicaid outpatient rule is minimal.
Health Information Technology (IT) **$19 Billion - $17 Billion in direct Medicare and Medicaid add-ons and $2 Billion in Grants**	Provides funding to HHS, states, hospitals, physicians and other health care providers to encourage the adoption and use of health IT systems and promote health information exchange. — The vast majority of the funding for this provision, $17 billion, will establish temporary Medicare and Medicaid payment incentives for hospitals and physicians for several years. In general, to be eligible for the temporary Medicare and Medicaid payment incentives, hospitals and physicians must already have in place a "certified electronic health record (EHR) system" and be a "meaningful user" of such a system. This would include using a "certified EHR system" that can exchange heath information and report on quality measures. These criteria, where not completely defined in the legislation, would be established by the Secretary. <u>Medicare Incentive Payments to Hospitals</u>: The Medicare incentive payment is built on a base amount of $2 million per hospital. This amount is adjusted upward based on a hospital's total all-payer discharges and then downward based on a hospital's Medicare percent. Medicare incentive payments will be phased-out over a four-year period beginning in FFY 2011. Medicare penalties, through reductions in the hospital marketbasket, will be phased-in starting in FFY 2015 for hospitals that are not "meaningful users." <u>Medicaid Incentive Payments to Hospitals</u>: The Medicaid incentive payment is designed in a similar fashion to Medicare incentive payment, adjusting the base amount by a hospital's Medicaid percent rather than the Medicare percent. To be eligible for the Medicaid incentive payments, a hospital must have Medicaid patient volumes of at least 10%. In addition to the "meaningful user" criteria, the state may have ability to establish additional criteria for hospitals to be eligible for the Medicaid incentive payments. — Additional funding, $2 billion, is provided to establish health IT grants for: • states (to promote health IT); • health IT infrastructure; • training; • dissemination of best practices;

Health IT - Continued	• telemedicine; and • inclusion of health IT in clinical education. — Standards: Establishes process to develop interoperability standards by FFY 2010 that will allow for secure nationwide electronic exchange of health information. Privacy and Security: Develops new and expands current federal privacy and security rules for health information and health information exchange that includes: • requiring an individual be notified if there is an unauthorized disclosure or use of their health information (breach notification); • requiring a patient's permission to use their personal health information for marketing purposes; and • allowing patients to request an audit trail of all disclosures of their EHR. Criteria related to standards and privacy/security where not completely defined in the legislation would be established by the Secretary.
Kansas Impact	Provider incentive payment formula based upon ratio of Medicare and Medicaid utilization to total patients for PPS hospitals – capped at $11 million to any given hospital. (Note: KHA is modeling the impact for hospitals and will be sending that information out as soon as it is available). For CAH hospitals the formula is different and a bit more complex. CAH's can receive 100% depreciation in year one of "meaningful" EHR system and then receive an additional 20% allowable cost to actual depreciation costs for four additional years.
Hospital Fundraising – "Opt-Out" Requirement	Requires hospitals, in any written fundraising communication, to provide an opportunity for the recipient to "opt-out" of receiving any further such communications. Signed authorization is not required by hospitals to contact patients, nor is a form required at admission. The effective date of this provision is one year from enactment of the bill.
Kansas Impact	Early versions of the bill prohibited hospitals from using EHR information for fundraising activities.
Access to Capital	Provides incentives for banks to purchase hospitals' tax-exempt bonds. This provision will increase from $10 million to $30 million the amount banks could deduct for buying and holding hospital bonds. This provision will apply for calendar years 2009 and 2010.
Kansas Impact	Makes hospital tax-exempt bonds more attractive to banks to purchase.

Medicare Hospice Wage Index **$134 million**	Reverses for one year (FFY 2009) the phase-out of the budget neutrality factor used to adjust the Medicare hospice wage index that went into effect on October 1, 2008 and requires the Secretary to recalculate the hospice wage index as if there had been no reduction in the budget neutrality adjustment factor. The Secretary has the authority to reverse the phase-out of the budget neutrality adjustment factor administratively.
Medicaid DSH Allocations to States **$500 million**	Provides a temporary increase in the amount of Medicaid DSH funding allocated to each state. 2.5 percent increase in both FFY 2009 and FFY 2010. This increase will not change the level of individual hospital DSH caps.
Kansas Impact	DSH payments to Kansas hospitals will increase by $845,000 for SFY 2009 and the same for SFY 2010. KHPA will adjust amounts pending availability of matching SGF to payout.
National Health Service Corps (NHSC) **$500 million**	Provides additional funding to the Health Resources and Services Administration (HRSA) for the NHSC program to train and pay a portion of medical school expenses for primary care physicians and other health care professionals who agree to work in medically under-served areas, both rural and urban.
National Institutes of Health (NIH) **$10 Billion**	Provides additional funding to the NIH to sponsor new research grants and for modernization.
Comparative Effectiveness Research **$1.1 Billion**	Provides funding to the Agency for Healthcare Research and Quality (AHRQ), NIH and HHS for research and the development of quality programs to compare the effectiveness of different medical treatments.
Preventative Health and Wellness Programs **$1.0 Billion**	Provides additional funding to HHS for preventive health and wellness programs including funding to fight preventable chronic and infectious diseases.

Community Health Centers **$2.0 Billion**	Provides funding to community health centers to modernize clinics, and make health IT improvements.
Kansas Impact	Undetermined at this time but funds will be made available to assist community health centers update and upgrade health IT improvements.
Consolidated Omnibus Budget Reconciliation Act (COBRA) Health Benefits **$21.4 Billion**	Subsidizes COBRA health benefits for 9 months, with the federal government paying 65% of the COBRA premium for workers who involuntarily lose their jobs between September 1, 2008 and December 31, 2009 and elect to receive health insurance through their former employer's health plan. Limits benefit to couples with annual incomes of less that $250,000 and individuals with annual incomes less than $125,000. Under current law, COBRA health benefits are available to workers for a total of 18 months.
Kansas Impact	Undetermined at this time but subsidies will be made available for newly uninsured and unemployed individuals and families to purchase COBRA-type insurance.

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To: Senate Public Health and Welfare Committee

From: Jerry Slaughter
Executive Director

Date: March 2, 2009

Subject: HIT provisions in H.R. 1, *the American Recovery and Reinvestment Act*

The Kansas Medical Society appreciates the opportunity to appear today as you review the health information technology provisions contained in H.R.1, the *American Recovery and Reinvestment Act* (ARRA), recently signed into law by President Obama. The specific provisions of ARRA that deal with health technology infrastructure are known as the *Health Information Technology for Economic and Clinical Health Act*, or ''HITECH." Our comments today will summarize only the provisions of HITECH that deal with incentives and penalties applicable to physicians for adoption and use of health information technology, and specifically electronic health records (EHRs).

First, however, we would like to make a few observations about the enactment of the sweeping health information technology provisions in ARRA, which of course, is the federal stimulus bill. This legislation was enacted with only the barest minimum of abbreviated public hearings and debate. The scope and reach of the information technology and privacy provisions in this legislation would, in any normal year, generate a significant amount of testimony, analysis, debate and probably numerous changes to many of the provisions. Obviously, as just one part of the federal stimulus legislation that was enacted hastily to address a crisis in the economy, there was little substantive discussion and very few details available about the health IT provisions prior to its enactment. The legislation delegates enormous, almost unprecedented, power to the Secretary of HHS and the National Coordinator for HIT on matters related to the gathering, exchange, protection and use of personal health information. Many in the health care community are skeptical that the centerpiece of the Act – the electronic health record – can produce all that is promised of it, including reducing costs. The legislation, through a combination of incentives and penalties, will basically compel the health care provider community in fairly short order to adopt electronic health records, from which patient care information can then be extracted and used for the purposes outlined in the Act. I think it is safe to say that the full extent of the impact and consequences of this new law won't be known for some time. However, it is now the law, and because it is just two weeks since its enactment, this is the extent of what we know about it at this point in time.

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HITECH provides an ambitious and extensive framework for the nationwide adoption of HIT for the stated purpose of reducing costs, eliminating medical errors and improving the quality of patient care. The Act grants the secretary of Health and Human Services, and HHS's Office of the National Coordinator for Health Information Technology (ONCHIT), broad powers and authority to fund, design and drive the establishment of a uniform HIT infrastructure nationwide. In all, HITECH contains $19 billion of federal stimulus funding to establish a national health information technology infrastructure intended to promote:

- the electronic exchange and use of health information and the enterprise integration of such information;
- the utilization of an electronic health record for every person in the United States by 2014;
- the incorporation of privacy and security protections for the electronic exchange of an individual's individually identifiable health information;
- strategies to enhance the use of health information technology in improving the quality of health care, reducing medical errors, reducing health disparities, improving public health, increasing prevention and coordination with community resources, and improving the continuity of care among health care settings;
- the reduction of health care costs resulting from inefficiency, inappropriate care, duplicative care, and incomplete information; and
- improved coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and
authorized exchange of health care information.

One of the key parts of the Act is to provide financial incentives to physicians and hospitals to adopt and demonstrate 'meaningful use" of electronic health records (EHRs). Meaningful use means that the provider's system must include e-prescribing, the electronic exchange of health information, and submission of certain clinical quality measures.

HITECH will incentivize the adoption of EHRs in several ways. Physicians who purchase and use EHRs will be eligible for increased Medicare reimbursement, with greater financial incentives in the early years to encourage providers to become early adopters. The incentive payments are limited to $18,000 in the first year, and on a decreasing scale in subsequent years, with no incentive payments after 2016. For physicians in rural health professional shortage areas, of which we have many in Kansas, the incentive payments are increased by 10%. The Act also provides financial incentives to physicians, rural health clinics and other providers who have significant Medicaid patient volume. Eligible pediatricians (non-hospital based), with at least 20 percent Medicaid patient volume could receive up to $42,500; other physicians (non-hospital based), with at least 30 percent Medicaid patient volume could receive up to $63,750 over a six-year period. Physicians could only access incentive payments in either Medicare or Medicaid, but not both. Additionally, physicians who do not adopt and use a certified EHR system would face reductions in their Medicare fee schedule beginning in

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2015. The penalties would increase from 1% in the first year to 3% in 2017, and the penalties could grow to 5% in 2019 and beyond.

The Act also allows the Secretary of HHS to award grants to states to facilitate EHR adoption, including loans to providers. The Secretary of HHS is also authorized to make EHRs available at nominal cost if the Secretary determines through a needs assessment that the needs and demands of providers are not being met through the marketplace.

In addition to the financial incentives to encourage the adoption of HIT/EHRs, the ONCHIT will be required to establish a health information technology extension program to provide technology assistance to assist health care providers to adopt, implement, and effectively use certified electronic health record (EHR) technology. The Secretary is also authorized to award grants to carry out demonstration projects to develop academic curricula integrating certified EHR technology in the clinical education of physicians and other health professionals.

In summary, ARRA, and more specifically, the HITECH provisions of the Act, set out a major initiative to establish a fully integrated, interoperable, health information system in the United States. The Act uses financial incentives in the Medicare and Medicaid programs - which together include the vast majority of licensed physicians in the country - to drive the adoption of EHRs. Because the Act is so new, the exact role of the states and other entities in this process is not yet fully understood. However, it is very likely that the Kansas Health Policy Authority will
play a major role in the administration of several elements of HITECH in our state. We look forward to working with KHPA in the coming months on this important endeavor.

Introduction

Chairman Barnett and members of the committee, thank you for the invitation to testify before you today. My name is Jeff Bloemker. I am here today on behalf of the 7,600 associates at Cerner Corporation to share our thoughts on healthcare policy, and the benefits of health information technology.

First, let me tell you a little bit about our company.

Cerner designs and implements software and services that deliver the right information to the right person at the right time and place to achieve optimal health outcomes.

We began in 1979, when three friends met at a picnic table at Kansas City's Loose Park to explore new business opportunities. Thirty years later, we have grown into a global healthcare company with offices in 12 different countries and revenues of $1.6 billion. We are the industry's leading supplier of healthcare information technology or what we call HIT solutions, and we're right here in your backyard.

Unrivaled Healthcare System is Broken

In the United States, the quality of our medical talent and scientific discovery is unparalleled. Conditions that were once a death sentence are now curable. Devastating diseases are now treatable. On the other hand, growth in healthcare expenditures has outpaced the rest of the economy for the past 40 years, and healthcare expenditures now represent more than 16 percent of the GDP. All forecasts expect this differential to continue with no end in sight.

The need to slow or reverse the growth in healthcare costs is compelling; especially over the next 30 years as the baby boomers age. President Obama recently said that the state of healthcare in the United States is "part of the [economic] emergency," and that reform must be "intimately woven into our overall economic recovery plan." We believe strategic investment in information technology can reduce healthcare expenditures. In crisis there is opportunity, and we must seize this generational opportunity to reconfigure our healthcare system.

American Recovery and Reinvestment Act

In the American Recovery and Reinvestment Act, the Obama administration has set aside $19 billion for health information technology, including $300 million to support Regional Health Information Exchanges. The act also includes money for prevention and wellness as well as a program for states to help doctor offices purchase electronic medical records through a loan fund. These are two topics I hope your committee will address in future hearings. President Obama is spending political capital to tackle healthcare reform. Included in my submitted testimony is a white paper by Cerner's CEO Neal Patterson addressing the need for disruptive innovation in reforming our entire healthcare system. For the sake of time, I will focus my remarks today on the role of health information technology as the foundation in creating the virtual health home.

Kansas

While talk of comprehensive reform on the federal level is heating up, meaningful reform is unlikely to happen any time soon. That puts Kansas and other states on the frontlines of healthcare reform. Kansas's current health system, like the nation's, is inefficient and fragmented. Performance is average—in one recent study, Kansas ranks 20th in the nation.[1]

Cerner has partnered with many states and communities as we worked to set up regional health information organizations (RHIOs) to exchange health information. Despite strong leadership and much time and effort, RHIOs

[1] The Commonwealth Fund 2007; State scorecard of health system performance across dimensions.

across the country are failing. Generally speaking, they lack a sustainable financing model and adoption of the system is low. Patients also distrust systems that provides no transparency to the use of their personal health data.

Through the leadership of Dr. Marcia Neilson, the Kansas Health Policy Authority has been on the front lines of efforts to address these issues. In Sedgwick County, through the deployment of the community health record to the Medicaid population, KHPA and Cerner have seen the positive financial and health outcomes of these early efforts. More importantly, we have also seen the promise of the patient-centered health home. Clinicians in Sedgwick County realize the value of an electronic health record in treating the complex needs of the Medicaid population, and it would be a great location to pilot the virtual health home.

Health Record Banks

To address the important issue of ownership and privacy of health information, Cerner has worked with a diverse coalition to back the concept of health record banking. This idea was born through the bipartisan efforts of Senator Sam Brownback and Congressman Dennis Moore who have introduced health bank legislation in the past two Congresses.

Ownership

Currently, consumers manage their own bank accounts, investments and purchases online. Why shouldn't they have the same power over their medical records? Health banks would give consumers ownership of—and control over—their healthcare records. These banks would empower consumers to choose who may see their private information. They also would allow for co-ownership rights over health data. Healthcare entities would still have a legal responsibility to hold their fragmented records, but legally, consumers would own a copy of their complete, lifetime health record.

Privacy

Health record banks would protect the consumer's health record like money in the bank. These consumer-owned institutions would manage medical data much in the same way financial institutions, such as banks and credit card companies, manage financial data. In emergency situations, healthcare providers could see a preauthorized, limited data set from the account. Health banks, as well as anyone with access to protected health information, would have to comply with the Health Insurance Portability and Accountability Act (HIPAA)—a protection not currently afforded to today's online personal health records.

Health Homes for Healthy Kansans

Kansas needs to fundementally shift how we deliver healthcare. Cerner believes healthcare information technology forms the foundation for this fundamental shift. People—not doctors, transactions or insurance companies—must be at the center of our system. We call this idea the Health Home, a concept first introduced by the American Academy of Pediatrics in 1967.

Linking Providers

In our model, consumers would enroll in a health record bank to link to their health home, a coordinated group of health professionals who help them manage their health.

Secure electronic communication would connect the members of this team, enabling coordinated approaches to care. Repetitive tests, for example, would become a thing of the past because providers would have access to all of a person's medical test results over time.

Each of us benefit from having healthcare providers who understand our health history, our personalities and our ability to respond to recommendations. This understanding is especially important in the treatment of those who have one or more chronic conditions. The health home and health record banks can make this coordinated approach to care a reality.

Focus on the Person

Our healthcare system must start and end with the person. Through a combination of information technology and financial reform, the health home can link the person with providers and payers, lowering costs while improving outcomes and access for everyone.

Through the Kansas Health Policy Authority and their subsequent recommendations, Kansas has begun to focus on the medical home concept. We applaud the authority's recommendations, and we are committed to working with the state on these important initiatives.

Kansas as a Laboratory of Reform

CareEntrust

Some of the larger employers in Kansas—Sprint and Yellow Freight to name a few—have joined with Cerner to create CareEntrust. This employer-based precursor to a health bank is the only such organization in the nation. The coalition includes 24 partner sponsors and 100,000 covered lives, including Kansas state employees in eastern Kansas.

In general, these electronic records help physicians keep an eye on patients, making sure they're seen regularly. They also help rural doctors who need to stay connected to the office while making rounds, and emergency room staff members who often need to treat patients who cannot speak for themselves.

At Cerner, we'd like Kansas to adopt the CareEntrust record for the lives for which state is responsible, including state employees, Medicaid recipients, foster children, State Children Health Insurance Program beneficiaries. We would also like to see Kansas request a waiver from CMS to include Medicare lives, a step already taken by North Carolina, Arizona and Utah. Your colleagues in Missouri and Oklahoma are considering the same proposal. By joining together in this unique initiative, your leadership will create a national showcase proving that states remain the laboratories of reform.

In Closing

We understand that timing is critical, and we renew our commitment to working with you to transform healthcare in Kansas. We also hope that you'll consider creating a record for the lives for which you are responsible by enrolling them in CareEntrust, and utilizing the ground work laid by the Sedgwick County CHR to pilot the virtual health home concept.

I would also like to extend an invitation to visit us in Kansas City for a tour of our Vision Center where we can explore some of these ideas in greater depth.

Thank you again for allowing me to testify before your committee.